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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH ✓

20473

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 5421

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County ST LOUIS
(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Christian Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
(c) City or town St Louis 6
(If outside city or town limit, write "RURAL")
(d) Street No. 5905 Theodosea Av.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME JENNETTE COWLES HAN

8. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White
6. (b) Name of husband or wife Marshall Cowles
7. Birth date of deceased 02 8 1907
(Month) (Day) (Year)

8. AGE: Years 32 Months 3 Days 14
If less than one day, hr. _____ min. _____

9. Birthplace Michigan
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Wm. Coppalman

13. Birthplace Holland
(City, town, or county) (State or foreign country)

14. Maiden name Van Ringer

16. Birthplace Holland
(City, town, or county) (State or foreign country)

16. (a) Informant Marshall Cowles

(b) Address 5905 Theodosea Av.

17. (a) Ship (b) Date thereof 6 27 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grand Rapids Mich.

18. (a) Signature of funeral director J. Muller

(b) Address 5765 Delmar Blvd.

19. (a) JUN 24 1940 (b) J. P. Brendek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23
year 1940 hour 6:30 minute A M.

21. I hereby certify that I attended the deceased from December
1939, to June 23, 1940;

that I last saw her alive on June 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Uremic poisoning Duration 2 days

Due to She has had for a few months a
4 + sugar in urine

Other conditions Organic Valvular Heart lesion
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature J. P. Brendek (M. D. or other)
Address Physician Medical Bldg. Date signed 6/27/40

92a

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed John Jetter
Licensed Embalmer No. 3880

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 5421

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Jennette Cowles

3. (b) If veteran, name was _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 32 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country).

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-9-40 (b) JF Bredet
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

20. DATE OF DEATH: Month June day 23 year 40
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that I last saw him alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Uremic poisoning 2h
Due to Few months 4+
sugar in urine

Other conditions Organic valvular
(Include pregnancy within 3 months of death)
heart lesion

Major findings: non prespical. Kidney
Of operations: stopped functioning, cap
underpin

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

1B
40
2659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20473**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **2421**

1. PLACE OF DEATH:

(a) County **St Louis**
(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Jennette Cowles**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **32** Months **8** Days **14** If less than one day hr. min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **JAN 9 1941** (b) **J.F. Bredek** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month **June** day **23** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that I last saw h. _____ alive on _____ 19 _____; and that death occurred on the date and hour stated above.

Immediate cause of death **Uremic Poisoning following Chr. Nephritis**
Due to **she has had for a few months a UT sugar due on urine**

Other conditions **Organic Valvular heart lesion**
(include pregnancy within 3 months of death)

Major findings: **131**
Of operations _____

Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature **W. Shag** (M. D. or other) _____
Address **Fabens Medical** Date signed _____

WRITE PLAINLY--USE NON-FADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY