

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27321
Registrar's No. 7217

Registration District No. 7911 Primary Registration District No. 1003

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:
St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community 3 days
years, months or days)

3. (a) PRINT FULL NAME ADELE BOWMAN ABT
3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Paul S. Abt 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Jan 30 1880
(Month) (Day) (Year)

8. AGE: Years 59 Months 6 Days 28
If less than one day hr. min.

9. Birthplace East St. Louis Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Frank B. Bowman
13. Birthplace Knobnoster Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Anne Griffith
15. Birthplace East St. Louis Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]

(b) Address East St. Louis Illinois

17. (a) Removal (b) Date thereof Aug. 27/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East St. Louis Ill.

18. (a) Signature of funeral director [Signature]
(b) Address East St. Louis, Ill.

19. (a) AUG 27 1940 (b) [Signature]
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County St. Clair
East St. Louis NR
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. Signal Hill Blvd.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 27
year 40 hour 3:37 minute 9 M.

21. I hereby certify that I attended the deceased from 8/25/40
_____ 19 to 8/27/40 19;
that I last saw h er alive on 8/27/40 19;
and that death occurred on the date and hour stated above.

Immediate cause of death
Aggravated typhoid
or
granulocytopenia
Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

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

Major findings:
Of operations _____
Of autopsy _____

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

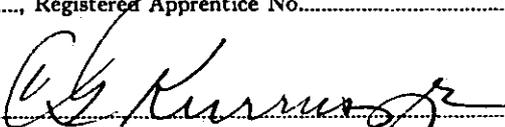
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....


Licensed Embalmer No. 3162

P. O. Address East St. Louis, Ill.

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.