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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 19999

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 4811

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

00
17
9

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL U
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County ST. L

(c) City or town EDINA N.R.
(If outside city or town limits, write "RURAL")

(d) Street No. U
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME DAWSON LAFE FOWLER

3. (b) If veteran, name war World War

3. (c) Social Security No. Unknown

4. Sex Male ()

5. Color or race White

6. (a) Single, widowed, married, divorced Single U

6. (b) Name of husband or wife Single

6. (c) Age of husband or wife if alive years

7. Birth date of deceased July (Month) 7 (Day) 1889 (Year)

8. AGE: Years 51 Months 11 Days 2 If less than one day hr. min.

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

10. Usual occupation Steward

11. Industry or business C.B.&Q. R.R.

MOTHER FATHER

12. Name C.R.Fowler

13. Birthplace Knox Co. (City, town, or county) U Missouri (State or foreign country)

MOTHER

14. Maiden name Cora E.Dawson

15. Birthplace Nodaway Co. (City, town, or county) U Missouri (State or foreign country)

16. (a) Informant C.R.Fowler

(b) Address Edina, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/10/41 (Month) (Day) (Year)

(c) Place: burial or cremation Edina, Mo.

18. (a) Signature of funeral director Albert H.Hoppe

(b) Address 4700 Washington Ave.

19. (a) JUN 10 1941 (Date received local registrar) (b) J. H. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 9 year 1941 hour 1 minute 00 P.M.

21. I hereby certify that I attended the deceased from May 28, 1941, to June 9, 1941; that I last saw him alive on June 9, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Multiple brain abscesses — Duration

Caused by bronchiectasis

Due to Bronchiectasis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy As above

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 U

23. Signature H. Bradley (M. D. ~~or coroner~~)

Address BARNES HOSPITAL Date signed 6-9-41

(Licensed Embalmer's Statement on Reverse Side)

JUL 22 1941

## 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 J. Wm Bierbley

Licensed Embalmer No. 3653

P. O. Address St Louis Mo.

**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, fact should be so stated above.**