

28 1941 791

1003

State File No. \_\_\_\_\_  
Registrar's No. 6160

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(c) Name of hospital or institution: St. Louis City Hospital #1  
(d) Length of stay: In hospital or institution 14 Days  
In this community 11 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(d) Street No. 3700 South Main St.  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Christ Bowman

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased August 16, 1873

8. AGE: Years 67 Months 11 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Germany

10. Usual occupation Nil.

11. Industry or business Nil.

12. Name William Bowman 13. Birthplace Germany

14. Maiden name Carrie (Unknown) 15. Birthplace Germany

16. (a) Informant Ann Morrison

(b) Address St. Louis City Hospital #1

17. (a) \_\_\_\_\_ (b) Date thereof 7-28-41

(c) Place: burial or cremation College of Mortuary Science

18. (a) Signature of funeral director W. Rutger

(b) Address 3579 Rutger

19. (a) JUL 29 1941 (b) J. M. Rutger

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23, year 1941 hour 12:45 minute A. M.

21. I hereby certify that I attended the deceased from July 10, 1941 to July 23, 1941; that I last saw him alive on July 23, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 1/2/41  
(Include pregnancy within 3 months of death)

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 R. J. Maxwell M. D. or other \_\_\_\_\_

Address 1516 Lafayette Ave. Date signed 7/23/41

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....

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, fact should be so stated above.**