

1. PLACE OF DEATH:

(a) County St. Louis, Mo
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain
(c) City or town Mexico
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Elizabeth Stowers

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased May 12 1891
(Month) (Day) (Year)

8. AGE: Years 51 Months 3 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name T. W. Stowers

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

14. Maiden name Rachel Wakefield

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

16. (a) Informant Mrs John Stowers

(b) Address Mexico, Missouri

17. (a) Burial (b) Date thereof 9/11/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mexico, Missouri

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

(b) Address 4700 Washington Ave.

19. (a) SEP 9 1942 (b) J. F. Beebeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9
year 1942 hour 2:10 minute _____ A.M.

21. I hereby certify that I attended the deceased from Sept 2, 1942, to Sept 9, 1942, that I last saw h.e.v. alive on Sept 9, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 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? _____

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

23. Signature J. H. O'Reilly (M. D. or other) MD

Address HARNE Date signed 9/19

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

MOTHER FATHER

SEP 25 1962

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.....

Esj W. Wilkinson

Licensed Embalmer No.....

35-78

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.