No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 28 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39656

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 10657

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: CHRISTIAN Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 Mo. 4 Day (Specify whether years, months or days)
In this community: 1 Mo. 4 Day

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St Louis
(c) City or town: JENNINGS Mo
(If outside city or town limits, write "RURAL")
(d) Street No.: 8809 Troeller Dr
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: JOHN CLETUS FOWLER
3. (b) If veteran, name war: NONE
3. (c) Social Security No.: NONE
4. Sex: MALE
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: Oct. (Month) 15 (Day) 1947 (Year)

8. AGE: Years | Months: 1 | Days: 4 | If less than one day: hr. min.

9. Birthplace: St Louis (City, town, or county) (State or foreign country)
10. Usual occupation: — NONE —
11. Industry or business:
FATHER 12. Name: CLETUS FOWLER
13. Birthplace: Ohio (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: FLOSSIE MORRIS
15. Birthplace: ARKANSAS (City, town, or county) (State or foreign country)
16. (a) Informant: Cletus Fowler
(b) Address: 8809 Troeller Dr.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: NOV. 20 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: FRIEDENS CEM.
18. (a) Signature of funeral director: Friedrich T. Hoppe
(b) Address: 8319 Halls Ferry Rd
19. (a) NOV 20 1947 (Date received local registrar) (b) J. F. Brockerhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19 year 1947 hour 3 minute A. M.
21. I hereby certify that I attended the deceased from Sept 18, 1947, to Oct 18, 1947 that I last saw him alive on Oct 18, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia (worm)	2 days
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy: Pneumonia

PHYSICIAN — Underline the cause of 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: J. R. Brooks (M. D. or other)
Address: 8209 N Broadway Date signed: Oct 19 1947

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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. Arthur R. Diedrich

Licensed Embalmer No. 3556

P. O. Address Mt. Vernon

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.