

FILED DEC 8 1948 **318**

1005

Registration District No. **318**

Primary Registration District No. **1005**

Registrar's No. **10413**

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Will Dowd

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

4. Sex Male 2. Color or race Col
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Mar. 8
(Month) (Day) (Year)

8. AGE: 67 Years Months Days If less than one day
79 hr. min.

9. Birthplace Georgia
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business

12. Name Jack Dowd
13. Birthplace Ga.
(City, town, or county) (State or foreign country)
14. Maiden name Anna
15. Birthplace Ga.
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth Rhodes

(b) Address 2601 N Whittier

17. (a) Anatomical Board (b) Date thereof NOV 30 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) NOV 30 1948 (Date received local registrar) J. B. Ranta (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2706 Thomas
21 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27
year 1948 hour 11 minute 25 a. M.

21. I hereby certify that I attended the deceased from Oct. 9 19 48 to Oct. 27 19 48
that I last saw in alive on Oct. 27 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Pyelonephritis, Bilateral; Cystitis
Duration Undet.

Due to.....
Due to.....

Other conditions Hypertrophy of Prostate
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy None
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?.....

23. Signature Helas O'Brien (M. D. or other).....
Address 2601 N Whittier Date signed NOV 30 1948
(Specify type of place) (g) Means of injury.....

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

MOTHER FATHER

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.