

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14519

FILED MAY 5 1950

State File No. 3746
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township): OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township): OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4940 Botanical Ave.		e. STREET ADDRESS (If rural, give location) 4940 Botanical Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Philadelphia b. (Middle) Fowler c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) April 22, 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 28, 1873
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 60 YRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Danforth, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME James Cloke	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE William Fowler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME William Fowler, 4940 Botanical		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adeno. Carcinoma Ovary Left Ovarian Metastases ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Hypostatic Pneumonia	
INTERVAL BETWEEN ONSET AND DEATH Dec. 1949		19a. DATE OF OPERATION 12/17/49	
19b. MAJOR FINDINGS OF OPERATION Adeno-Carcinoma Left Ovary - Inoperable 12/21/49		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 175X		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12/17, 1949 , to 4/22, 1950 , that I last saw the deceased alive on 12/18, 1950 , and that death occurred at 5:15 P.M. m., from the causes and on the date stated above.			
23a. SIGNATURE J. J. Wellman B.S. M.D.		23b. ADDRESS 8321 No. Ridgeway	
23c. DATE SIGNED 4/24/50		24a. BURIAL / CREMATION / REMOVAL (Specify) Removal	
24b. DATE 4-24-50		24c. NAME OF CEMETERY OR CREMATORY City	
24d. LOCATION (City, town, or county) (State) Ashkum, Ill.		DATE REC'D BY LOCAL REG. APR 24 1950	
REGISTRAR'S SIGNATURE J. B. Sasater		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd.	
ADDRESS		ADDRESS	

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Elmo R. Caldwell

Signed.....
Student Embalmer

Licensed Embalmer No. 4077

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.