

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44018

FILED DEC 20 1952

542 State File No. 543 Registrar's No. 3104

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>543</u>		Registrar's No. <u>3104</u>			
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) <u>JENNIN-GS</u>		c. LENGTH OF STAY (In this place) <u>7 hrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		<u>3198</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Halls Ferry Memorial Home</u>				d. STREET ADDRESS (If rural, give location) <u>4448 McPherson</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>S.</u> c. (Last) <u>Bowers</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 3, 1952</u>						
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 19, 1863</u>		9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Herkert & Meisel</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Union City, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>J. S. Bowers</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Walsa M. Bowers</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-05 1312</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Walsa M. Bowers</u>				ADDRESS <u>4448 McPherson</u>	
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) <u>Carcinoma of brain - metastatic</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of esophagus</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>150X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 Mo.</u> <u>7 Mos.</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 <u>Oct 8, 1952</u> to <u>Dec 2, 1952</u> , that I last saw the deceased alive on <u>Dec 2, 1952</u> and that death occurred at <u>12:50 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Thomas H. Buford M.D.</u>				23b. ADDRESS <u>600 E. Kingshighway</u>		23c. DATE SIGNED <u>12-3-52</u>			
24. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 6, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>12-4-52</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Dombke</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E. Hoffmeister Colonial Mortuary</u> <u>666 Chippewa St., St. Louis, Mo.</u>					

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

5X Licensed Embalmer's Statement on Reverse Side

Dr. Burford
Barnes Hospital
2:30 to 3:00PM Wed.
10:15AM Thurs.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broad

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.