

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45574

FILED JAN 19 1954

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State File No.

12281

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>0</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) OR TOWN <u>ST. LOUIS, MISSOURY</u>			c. LENGTH OF STAY (in this place) <u>6 weeks</u>	c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>5415 St. Louis Ave</u>		<u>2069</u>		<u>0</u>	
3. NAME OF DECEASED (Type or Print)		a. (First)	b. (Middle)	c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
<u>ALICE</u>				<u>SOWERS</u>		<u>DECEMBER 27, 1953</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Apr. 13, 1875</u>		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	Hours	
					<u>78</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Linn, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>(late) James Sowers</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mary Angleton, 5415 St. Louis</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH		
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized arteriosclerosis</u>								
	ANTECEDENT CAUSES								
	Morbid conditions, if any, giving DUE TO (b) _____								
	DUE TO (c) _____								
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4500</u>					
22. I hereby certify that I attended the deceased from <u>10-12-53</u> , 19 <u>53</u> , to <u>12-27-53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>12-27-53</u> , 19 <u>53</u> , and that death occurred at <u>6:30P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Edward P. Flynn M.D.</u>				23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>12-28-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>Dec. 30, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis - Missouri</u>					
DATE REC'D BY LOCAL REG. <u>DEC 29 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leidner Und Co 2223 St. Louis Ave</u>					

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *John P. Buchholz*

Licensed Embalmer No. *1167*

P. O. Address *2223 St*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.