

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5849

State File No. \_\_\_\_\_

FILED MAR 9 1954

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 62

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>City of St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Farmington Rural St. Francois</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis, 2139</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri State Hospital No. 4</b>		d. STREET ADDRESS (If rural, give location) <b>5400 Arsenal (City Sanitarium)</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>CHARLES</b>		b. (Middle) <b>JAMES</b>	
c. (Last) <b>BOWEN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>March 1, 1954</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Dec. 30, 1891</b>
9. AGE (In years last birthday) <b>62</b>		10. MONTHS <b>2</b>	11. DAYS <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Common labor</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Unknown</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Never Married</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Records, State Hospital No. 4, Farmington, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs.</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) <b>Hypertensive cardiovascular renal disease</b>		Unknown	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS	
Dementia Praecox Psychosis - - - - - at least 20 yrs.		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>July 19, 1952</u> , to <u>March 1, 1954</u> , that I last saw the deceased alive on <u>March 1, 1954</u> and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <i>John A. Brennan M.D.</i>		23b. ADDRESS <b>State Hospital No. 4, Farmington, Mo. 3-2-54.</b>	23c. DATE SIGNED
24a. BURIAL/CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>March 4, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Department, Washington Univ., St. Louis, Mo.</b>	24d. LOCATION (City, town, or county) (State)
DATE RECD BY LOCAL REG. <b>Mar. 3, 1954</b>	REGISTRAR'S SIGNATURE <i>Ethel Rudloff</i>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Miller Funeral Home, Farmington, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

0.300  
0.48

9402

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 \_\_\_\_\_

*not embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed: \_\_\_\_\_

*Beek Dyal*

Licensed Embalmer No. *4120*

P. O. Address \_\_\_\_\_

*Fernington*

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.