

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13298

State File No. ....

2966

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LUKES HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>2035 ALFRED</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>ELLEN</b> b. (Middle) <b>BOWLING</b> c. (Last) <b>CLEVE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 1, 1954</b>	
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>NOV. 19, 1882</b>
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>ST. GENEVIEVE, MO.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>W. MADISON BOWLING</b>	
13b. MOTHER'S MAIDEN NAME <b>MARY V. DILCHEMENDY</b>		14. NAME OF HUSBAND OR WIFE <b>JOHN L. CLEVE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>MISS VIRGINIA CLEVE</b>		ADDRESS <b>2035 ALFRED</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of bile ducts</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 checked="" type="checkbox"/> NO <input 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) <b>155X</b>			
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 <b>9-17</b> , 19 <b>53</b> , to <b>4-1</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>3-31</b> , 19 <b>54</b> , and that death occurred at <b>2:15 A. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Arthur B. Day, M.D.</b>		23b. ADDRESS <b>3720 Washington</b>	
23c. DATE SIGNED <b>4-1-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>APRIL 3, 1954</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>FARMINGTON, MO.</b>		24d. LOCATION (City, town, or county) (State) <b>FARMINGTON, MO.</b>	
DATE REC'D BY LOCAL REG. <b>APR 1 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>E. HOFFMEISTER</b>		ADDRESS <b>COLONIAL MORTUARY, 6464 CHIPPEWA ST. (9)</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

DR. A. B. RAY.  
3720 WASHINGTON

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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 *Lenius C. Hoffmann*

Licensed Embalmer No. 387

P. O. Address *7814 S. B.*

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.