S. No. 300
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FILED JUL 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21535

BIRTH NO. ____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 1309

1. PLACE OF DEATH
a. COUNTY St Louis Co
b. CITY OR TOWN (If outside corporate limits write RURAL and give township) Clayton Mo
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Louis Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Louis
c. CITY OR TOWN (If outside corporate limits write RURAL and give township) Robertson Missouri 4070
d. STREET ADDRESS (If rural, give location) Woodland ave

3. NAME OF DECEASED (Type or Print)
a. (First) Mathilda
b. (Middle)
c. (Last) Fowler

4. DATE OF DEATH (Month) (Day) (Year) May 30, 1954

5. SEX F.M. 1
6. COLOR OR RACE N.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Dec. 6, 1892
9. AGE (In years last birthday) 71 — 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) House wife
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (City and State or Foreign Country) Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jim Layton
13b. MOTHER'S MAIDEN NAME M. Layton
14. NAME OF HUSBAND OR WIFE Bud Fowler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service) no.
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME Joe Field — 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL VAS. ACCIDENT

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 331X
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-30, 1954, *to* 5-30, 1954, *that I last saw the deceased alive on* 5-30, 1954, *and that death occurred at* 11:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Ronald Hoffmann (Degree or title) M.D.
23b. ADDRESS 601 S. Brentwood, Clayton, 5, Mo.
23c. DATE SIGNED 5/31/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-5-54
24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery
24d. LOCATION (City, town, or county) (State) St Louis Co. Mo.

DATE REC'D BY LOCAL REG. 6-5-54
REGISTRAR'S SIGNATURE Herbert R. Domke M.D.
25. FUNERAL DIRECTOR'S SIGNATURE Hodnick Funeral Home — ADDRESS Robertson

(Licensed Embalmer's Statement on Reverse Side)

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 .....
Student Embalmer

Signed Leroy. U. Sannisto

Licensed Embalmer No. 4523

P. O. Address 3880 Easton A

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.