

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20028

State File No.

4901

FILED JUN 22 1955

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)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Illinois	b. COUNTY Pulaski
c. LENGTH OF STAY (in this place) 12 days	c. CITY OR TOWN Mounds	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital		STREET ADDRESS (If rural, give location) 410 Sycamore - St 812-9	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Pamela	b. (Middle) Jo	c. (Last) Fowler	6-3-55		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 9-18-53	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months 9 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None -		10b. KIND OF BUSINESS OR INDUSTRY None -		11. BIRTHPLACE (City and State or Foreign Country) Illinois	
13a. FATHER'S NAME John M. Fowler			13b. MOTHER'S MAIDEN NAME Georgia Lyons -		14. NAME OF HUSBAND OR WIFE None -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Johnston ADDRESS 500 S. Kingshighway	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) BRAIN TUMOR			
		ANTECEDENT CAUSES			
		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 6-3-55		19b. MAJOR FINDINGS OF OPERATION Calcified Brain Tumor - Choroidal cyst?		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)	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 193x	
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22. I hereby certify that I attended the deceased from **5-23-1955**, to **6-3-1955**, that I last saw the deceased alive on **6-3-55**, ~~1955~~, and that death occurred at **5:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Am L Johnston (Degree or title) MD		23b. ADDRESS Childrens Hospital		23c. DATE SIGNED 6-4-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 6-4-55		24c. NAME OF CEMETERY OR CREMATORY CARIO	
				24d. LOCATION (City, town, or county) (State) ILL	

DATE REC'D BY LOCAL REG. JUN 6 1955		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Bennie Love ADDRESS 3103 Washington	
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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 *M. Claude Gordon*

Licensed Embalmer No. *34*

P. O. Address *4575 V*

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.