

AMENDED FILED AUG 18 1961 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7444 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 5017 Kensington	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALDORA FOWLER			4. DATE OF DEATH Month Day Year AUGUST 9 1961
5. SEX F.	6. COLOR OR RACE C	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH APR. 23 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MIT		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 50
11a. FATHER'S NAME WILL WARREN		11b. MOTHER'S MAIDEN NAME MARY HARVEY	9. AGE (last birthday) 3
11c. NAME OF HUSBAND OR WIFE James Fowler		12. CITIZEN OF WHAT COUNTRY U.S.A.	
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.	17. INFORMANT James Fowler 5017 Kensington
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE AND UREMIA DUE TO (b) CHRONIC PYELONEPHRITIS DUE TO (c) CONGENITAL HYPOPLASTIC KIDNEYS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC STAPHYLOCOCCAL INFECTION OF NECK. CONGESTIVE HEART FAILURE. SUBSTERNAL THYROID GOITER			INTERVAL BETWEEN ONSET AND DEATH YEARS YEARS 50 YEARS
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from JUNE 20, 1960 to AUGUST 9, 1961 and last saw her him alive on AUGUST 9, 1961 Death occurred at 11:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE C. D. Vermillion, M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 8/10/61
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 8-15-61	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PK.
23d. LOCATION (City, town, or county) St. Louis Co., Mo.		23e. DATE RECD. BY LOCAL REG. AUG 10 1961	
24. FUNERAL DIRECTOR WALTER STODDARD		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

H. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 11237 Jayl

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.