

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-035949

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318

1956 884

SL 28805

Primary Registration District No. 1003

Registrar's No. 8758

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 17 1962

<b>1. PLACE OF DEATH</b> a. COUNTY  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>915 N. Grand, St. Louis, Mo.</u> Length of stay in 1b <u>67 days</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY  c. CITY OR TOWN <u>Livingston</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET. ADM. HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>- - - - -</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MELVIN L. BOWCOTT</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>SEPTEMBER 8 1962</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9/10/95</u>	<b>9. AGE (last birthday)</b> <u>66</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>St. David, Illinois</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>JOHN BOWCOTT</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>MARY LAMB</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>ROSE BOWCOTT</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW-1</u>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Rose Bowcott (Wife), Same add. as 2.</u>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA RIGHT LUNG</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>163x</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY STATE	

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY STATE	
<b>21. Attended the deceased from</b> <u>7/3/62</u> to <u>9/8/62</u> and last saw him alive on <u>9/8/62</u> Death occurred at <u>12:15 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

<b>22a. SIGNATURE</b> <u>Drew W. McRobertson</u>		<b>22b. ADDRESS</b> <u>VAH, ST. LOUIS, MO.</u>		<b>22c. DATE SIGNED</b> <u>9/8/62</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>23b. DATE</b> <u>Sept 11, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Douglas</u>	
<b>23d. LOCATION</b> (City, town, or county) (State) <u>New Douglas Illinois</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>MANAL FUNERAL Home De Soto Mo.</u>			

<b>25. DATE RECD. BY LOCAL REG.</b> <u>SEP 11 1962</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Carl Smith - M.D.</u>	
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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

*Donald J. Mahan*

Licensed Embalmer No.

*4975*

P. O. Address

*De Soto, Mo*

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.