

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043997

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11872** STATE FILE NUMBER

FILED DEC 14 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits
St. Louis		St. Louis		1 week	Mo.		St. Louis		Clayton		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits		d. STREET ADDRESS (If outside, give location)				Reside on Farm	
Deaconess Hospital				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		7728 Shirley Dr.				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year	
ELEANOR					BOWMAN	December 9, 1962					
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR				
Female	White		10/19/78	84	Months		Days		Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
Housewife				None		St. Louis, Mo.		USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
Fred Stoacker				Johanna Niebuhr			Lee L. Bowman, Dec'd.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
No				None		Miss Emma Stoacker, 7728 Shirley Dr. Clayton Mo.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE											
DUE TO (b) _____											
DUE TO (c) 420.0											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): CHOLELITHIASIS											
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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.											
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from FEB 2 1952 to DEC 9 1962 and last saw her alive on DEC 9 1962 Death occurred at 8:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED		
<i>Henry Stoecker M.D.</i>						818 OLIVE ST			Dec 11 '62		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		23e. STATE		
Removal			12/12/62		Memorial Park Cemetery		Cape Girardeau, Mo.				
24. FUNERAL DIRECTOR ADDRESS					25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE				
Louis H. Bopp, Inc., Kirkwood, Mo.					DEC 11 1962		<i>Paul Smith, M.D.</i>				

VS 300 Rev. 4/59

1
240023

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

58

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

Francis J. W. [Signature]

Licensee Embalmer No. 4512

P. O. Address Richmond, 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.