

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City St. Louis Mo. (No. City, Sanitarium)

File No.....

3458

Registered No.....

1094

St. _____ Ward _____

2. FULL NAME

Beccelia Lowe

(a) Residence. No. 117 W. Perry St., 13 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 4 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Charles Lowe

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Jan. 2, 1865.

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, _____ hrs. or _____ min.

62

-

28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown Louisiana

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT Frank Tracy M.D.

(Address) 5400 Arsenal St.

15.

FILED JAN 31 1927 May 6 Starkeoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 30 1927

17.

I HEREBY CERTIFY, That I attended deceased from JUN 4, 1920, to JAN 30, 1927 that I last saw h. s. l. alive on JAN 29, 1927, and that death occurred, on the date stated above, at 6:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93C

(duration) 6 yrs. 7 mos. 17 ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Frank Tracy M. D.

1-30, 1927 (Address) 5400 Arsenal St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Calvary Cemetery

2/2 1927

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly 2039 Wash St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

