

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

Do not use this space.

19484

File No. _____
Registered No. **5075**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis, Mo.** (No. **5330 Persing**)

2. FULL NAME

Robert M. Lowe.

(a) Residence. No. **5330 Persing** St. **17** Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1, 1861		
7. AGE YEARS 67	MONTHS 10	DAYS 3
If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Accountant (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) **Tennessee**

10. NAME OF FATHER **James Lowe**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) **Tennessee**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) **Tennessee**

14. INFORMANT **Keene Lowe**
(Address) **5330 Persing Ave.**

15. FILED **5 1923** **Max C. Stanley**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 4 - 1929**

17. I HEREBY CERTIFY, That I attended deceased from **June 1, 1926** to **May 4, 1929** that I last saw him alive on **May 2, 1929** and that death occurred, on the date stated above, at **1:35 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
51B
Cerebral Hemorrhage
(duration) **3** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **49**
(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF _____

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS? **Microscopic**
(Signed) **Max C. Stanley** M. D.
5 1929 (Address) **506 Olive 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 **Memorial Park Cem** DATE OF BURIAL **5-7-1929**

20. UNDERTAKER **Ziegenfuss Bros. 2623 Cherokee**
ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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Dr. M. J. Glasser
506 Olive
