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

Do not use this space.

12810

1. PLACE OF DEATH

County Jackson — Registration District No. 399

Township Kaw — Primary Registration District No. 1002

City Kansas City (No. K.C. General Hospital St. Ward)

File No. [illegible]

Registered No. [illegible]

2. FULL NAME Daniel Lowe

(a) Residence. No. 744 Oak St. St., 1 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 25, 1873.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	57	0	26	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer None

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

PARENTS

10. NAME OF FATHER Joseph Lowe

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

12. MAIDEN NAME OF MOTHER Margarett Nation

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

14. INFORMANT Levina Lowe (Address) 744 Oak St.

15. FILED 4/21, 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-20- 1930

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner, 19..., to ..., 19..., that I last saw h..... alive on ..., 19..., and that death occurred, on the date stated above, at 3:45 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

93C

97

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

CONTRIBUTORY (SECONDARY) Chronic arterio sclerosis (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? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) Stanley McHall, M. D.

4/20, 1930 (Address) Deputy Coroner

*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
Highland Park Cemetary	4-22-30 19

20. UNDERTAKER	ADDRESS
J.P.Louis Funeral Director, City.	

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.

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