

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 421.13

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 11236

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4559a Garfield
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 4559a Garfield Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Henrietta Harris Lowe

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Low 6. (c) Age of husband or wife if alive About 75 years

7. Birth date of deceased Aug. 20 1866
(Month) (Day) (Year)

8. AGE: Years <u>73</u>	Months <u>4</u>	Days <u>9</u>	If less than one day hr. _____ min.
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9. Birthplace Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

12. Name Unknown

18. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Unknown Kentucky
(City, town, or county) (State or foreign country)

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Julia H. Le Claire

(b) Address 3208 Carson Rd. S. St. Louis
Burial Dec. 31-39

17. (a) _____ (b) Date thereof Dec. 31-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Russell Und. Co.

(b) Address 2732 Pine Street

19. (a) DEC 31 1939 (b) J. B. Budick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29th
 year 1939 hour 12 minute 30 M.

21. I hereby certify that I attended the deceased from Aug. 14th, 1939, to Dec. 29, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Heart disease

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature M. L. McGinnis (M. D. or other) _____

Address 8264 N. Beaumont Date signed 12/30/39

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Joel Russell
Licensed Embalmer No. 4112

P. O. Address.....

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 this body is not embalmed, above space should be left blank.