FILED APR 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8813

Registration District No. 791 Primary Registration District No. 1036 Registrar's No. 2296

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Deaconess Hospital, 6150 Oakland Ave. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks 2 days (Specify whether years, months or days) In this community 3 Weeks 2 Days

3. (a) PRINT FULL NAME EDWIN D. LOWIS

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Stella Schafer Lowis

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased March (Month) 30 (Day) 1900 (Year)

8. AGE: Years 39 Months 11 Days 8 If less than one day -- hr. -- min.

9. Birthplace Macoupin, Co. (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER 12. Name Charles E. Lowis

13. Birthplace Macoupin Co. (City, town, or county) Illinois (State or foreign country)

MOTHER 14. Maiden name Lillie Birkenmeyer

15. Birthplace Jersey Co. (City, town, or country) Illinois (State or foreign country)

16. (a) Informant's own signature X Walter L. Schafer

(b) Address Piasa, Illinois

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Piasa Cemetery

18. (a) Signature of funeral director Paul L. Warner

(b) Address Brighton, Ill.

19. (a) MAR 8 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Macoupin

(c) City or town Rural N.R. (If outside city or town limits, write "RURAL")

(d) Street No. Shipman Township, (If rural, give location)

(e) If foreign born, how long in U. S. A.? — years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7 year 1940 hour 12:20 minute P. M.

21. I hereby certify that I attended the deceased from Feb. 14, 1940, to March 7, 1940; that I last saw him alive on March 7, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Subdural hemorrhage Cerebellum	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Subdural Hemorrhage	
Of autopsy None	

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? Residence (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address 4957 Maryland Ave. Date signed

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 1 X19511

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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 Paul L. Warner

Illinois Licensed Embalmer No. 6841

P. O. Address Brighton, Ill

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.