

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9793**
Registrar's No. **1227**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kaw. Mo. K.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days)
In this community 18 years

3. (a) PRINT FULL NAME Walter E. Lowe
3. (b) If veteran, name war no
3. (c) Social Security No. 487-09-4721

4. Sex Male 5. Color or race wh
6. (a) Name of husband or wife unknown
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased Feb-14-1884
(Month) (Day) (Year)

8. AGE: Years 56 Months 1 Days 3
If less than one day by 59 min.

9. Birthplace Minneapolis Minn
(City, town, or county) (State or foreign country)

10. Usual occupation Supt. of Mill

11. Industry or business Flour

MOTHER FATHER
12. Name W. Lowe
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Jones
15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Roy Caldwell
(b) Address West Concord Miss

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

(c) Place: burial or cremation Minneapolis Minn

18. (a) Signature of funeral director Keller
(b) Address 6520 W. 11th St. St. Louis

19. (a) Mch 19, 1940 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 555 Stone Wall Court
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17
year 1940 hour 8 minute 9 A.M.

21. I hereby certify that I attended the deceased from Mar 3
1940, to Mar 17, 1940
that I last saw him alive on Mar 16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Hepatitis
Early portal cirrhosis
Due to 59
Due to _____

Other conditions Diabetes mellitus
(Include pregnancy within 3 months of death) 5 yrs

Major findings: Diabetes mellitus
Of operations _____

Of autopsy acute hepatitis portal cirrhosis, arteriosclerosis

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 ! MD.
23. Signature James H. Kelly (M. D. or other) MD.
Address 220 Professional Bldg Date signed 3-18-40

Duration

3 mos

?

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

01-1-19

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 *Wm. J. Ward*
Licensed Embalmer No. *3991*
P. O. Address *5725 Virginia*

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.