S. No. 2
—11-10-39
. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40546

Registration District No. 7911 1005

Primary Registration District No.

Registrar's No. 10317

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 2

912 A Ofallon (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community about 25

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0

(c) City or town St Louis 24 (If outside city or town limits, write "RURAL")

(d) Street No. 912 Ofallon (If rural, give location)

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

3. (a) PRINT FULL NAME Sarah Lowe

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Cal

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

6. (b) Name of husband or wife Nelson

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased July (Month) 15 (Day) 1882 (Year)

8. AGE: Years	Months	Days	If less than one day
58	4	28	hr. min.

9. Birthplace Greensville (City, town, or county) Miss (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace (City, town, or county) Miss (State or foreign country)

MOTHER
14. Maiden name Not Known
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Nelson Lowe
(b) Address 912 A Ofallon

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-40 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director G P Richardson
(b) Address 2625 Gravois

19. (a) DEC 16 1940 (Date received local registrar) (b) J H Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 12 year 1940 hour 8 minute 15 P.M.

21. I hereby certify that I attended the deceased from Dec 12 1940, to , 19 ; that I last saw her alive on Dec 11 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Aortic Insufficiency	6 mo
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

23. Signature J. T. Aldrich (M. D. or other)
Address St Louis Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 29 28

P. O. Address 2825 Glasgow

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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