S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 14 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18973

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5580

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: Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution A few hours (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 7030 Plateau
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Dewey S. Lower
3. (b) If veteran, name war None
3. (c) Social Security No. 702-09-0501
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Corinne
6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased May (Month) 12 (Day) 1898 (Year)
8. AGE: Years 47 Months 1 Days 15 If less than one day hr. min.
9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Ass't. Gen'l. Claim Agt.
11. Industry or business Amer. Refrigerator Transit Co.
MOTHER FATHER
12. Name Irene Lower
13. Birthplace Unknown (City, town, or county) West Va. (State or foreign country)
14. Maiden name Annie Kocian
15. Birthplace Milwaukee (City, town, or county) Wis. (State or foreign country)
16. (a) Informant Corinne Lower
(b) Address 7030 Plateau
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (Month) 30 (Day) 45 (Year)
(c) Place: burial or cremation Park Lawn Cemetery
18. (a) Signature of funeral director Kriegshauser Und. Co.
(b) Address 4228 So. Kingshighway Bl.
19. (a) JUN 27 1945 (Date received local registrar) J. F. Breed (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27 year 1945 hour 6:05 A.M. minute M.
21. I hereby certify that I attended the deceased from Jan 16, 1945, to 6/27/45, 19; that I last saw him alive on 6/27/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
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 C. C. Drace Jr. M.D. (M. D. or coroner)
Address Mo. Pacific Hospital Date signed 6/27/45

(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 Richard W. Storssand

Licensed Embalmer No. 4007

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, fact should be so stated above.