

S. No. 2  
OM-5-43  
V. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27546  
Registrar's No. 94

FILED AUG 30 1945  
Registration District No. 2

Primary Registration District No. 5572

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Prairie View  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Jackson County Home for Aged (white)  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yr. 4 mo. 5 day  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 3411 Highland  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELIZABETH Lowe

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13  
year 1945 hour 2:25 minute a.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife ?

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

7. Birth date of deceased October 18 1853  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1 1945 to July 13 1945  
that I last saw her alive on July 12 1945  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>91</u>	<u>8</u>	<u>25</u>	_____ hr. _____ min.

Immediate cause of death Senility

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace Jackson County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

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.

16. (a) Informant Records - Jackson County Home

(b) Address Rt #4, Independence, Mo.

17. (a) Cremation (b) Date thereof 7-16-45  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem K.C. Mo.

18. (a) Signature of funeral director D B Langford

(b) Address Leis Summit, Mo.

19. (a) July 14 - 1945 (b) F. M. Schick  
(Date received local registrar) (Registrar's signature)

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 F. M. Schick (M. D. or other) \_\_\_\_\_

Address Independence Mo Date signed 7/15/45

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**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. 13833

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.