

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **26844**

FILED AUG 30 1947

Registration District No.

Primary Registration District No. **1000**Registrar's No. **1012**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Missouri Methodist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days** (Specify whether **Lifetime**)
In this community **Lifetime**
years, months or days

3. (a) PRINT FULL NAME **FLORENCE LOWER**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Isaac** 6. (c) Age of husband or wife if alive **dead** years
7. Birth date of deceased **May 6, 1864**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
✓	83	3	14	hr. min.

9. Birthplace **Buchanan Co., Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business **Home**

12. Name **Nelson Hawley**

13. Birthplace **Vigo Co., Indiana**
(City, town, or county) (State or foreign country)

14. Maiden name **Samantha Moore**

15. Birthplace **Buchanan Co., Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Lower (Son)**

(b) Address **55 E. Valley St., City**

17. (a) **Burial** (b) Date thereof **8/20/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bethel Cemetery**

18. (a) Signature of funeral director **John B. Rupp**

(b) Address **6054 Pryor Ave., City**

19. (a) **8-25-47** (b) **E. B. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **55 E. Valley St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **17**,
year **1947** hour **1** minute **16 A.** M.

21. I hereby certify that I attended the deceased from **8/13/47**
8-19-47 19 **8-18-47** 19
that I last saw her alive on **8/17/47** 19
and that death occurred on the date and hour stated above
Immediate cause of death **Pneumonia - bilobes**
followed by
Streptococcus Periton.

Due to **Streptococcus Periton.**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: **✓** **12**

Of operations **✓**

Of autopsy **✓**

PHYSICIAN

Underline the cause of 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)

(e) Means of injury **✓**

23. Signature **J. B. Rupp** (M. D. or other)

Address **Joseph Mo** Date signed **8/20/47**

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

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.....
working under my personal supervision.

Signed.....
Registered Apprentice No.....
Licensed Embalmer No. 3986
P. O. Address St. Joseph, Mo.

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.