

FILED NOV 29 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38289

Registrar's No. 4839

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
9 East 51st Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
In this community 60 years (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. 2909 Euclid Avenue
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas Otis LOWELL

3. (b) If veteran, name war none
3. (c) Social Security No. 513-16-2811

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced, widowed
6. (c) Age of husband or wife if alive, years _____
7. Birth date of deceased: November 28, 1870
(Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days 21
If less than one day _____ hr. _____ min.

9. Birthplace Providence, Rhode Island
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Plumber

11. Industry or business Self

12. Name Samuel O. Lowell
13. Birthplace Orrington, Maine
(City, town, or county) (State or foreign country)
14. Maiden name Jennie Delay
15. Birthplace Greenville, N. S.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Thomas E. Lowell
(b) Address 2807 E. 33d St., K.C., Mo.
17. (a) Burial (b) Date thereof 11-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Melody-McGilley-Eylar
(b) Address Kansas City, Missouri

19. (a) 11-19-47 (b) Gertrude Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19
year 1947 hour 2 minute 03 A.M.

21. I hereby certify that I attended the deceased from May, 1947
to Nov. 19, 1947
that I last saw him alive on Nov. 18, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Due to arteriosclerosis and hypertension
Due to _____
Other conditions (include pregnancy within 3 months of death) 83a

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? _____

While at work? _____ (Specify type of place) (c) Means of injury 0

23. Signature Dr. Hagan M.D. (M. D. or other) _____
Address 801 1/2 W. 39 Date signed 11-19-47

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

MOTHER FATHER

Dr. D. Hager
801 1/2 W. 39th.
Va. 3660

after 2:30 -

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.....

Russell N. France

Licensed Embalmer No.....

4255

P. O. Address.....

A. C. 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.