

FILED APR 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14514

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 79

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall	
c. LENGTH OF STAY (In this place) 3 days		d. STREET ADDRESS (If rural, give location) 302 East North	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Fitzgibbons Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Edward	b. (Middle) -	c. (Last) Lowenstein	4. DATE OF DEATH (Month) (Day) (Year) April 18-1949
-------------------------------------	--------------------------	----------------------	-----------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH September 2, 1869-79	9. AGE (In years last birthday) 7	IF UNDER 1 YEAR 16 Months	IF UNDER 2 HRS. 0 Hours	IF UNDER 15 MIN. 0 Min.
--------------------	-------------------------------	---	--	--	----------------------------------	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	10b. KIND OF BUSINESS OR INDUSTRY Bought and sold Wool & Pelts	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	--	--

13a. FATHER'S NAME Julius Lowenstein	13b. MOTHER'S MAIDEN NAME Hannah Rose	14. NAME OF HUSBAND OR WIFE Single
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Herman Lowenstein-Marshall, Mo.	ADDRESS
---	-------------------------------------	--	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Glomerulonephritis DUE TO (c) Essential Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		2-3 yrs. years. 44 1/2	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **Jan 49**, to **Apr. 18, 1949**, that I last saw the deceased alive on **Apr. 17, 1949**, and that death occurred at **2:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE C. A. Weath (Degree or title) M.D.	23b. ADDRESS Marshall Mo	23c. DATE SIGNED 4-18-49
---	---------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Reburse	24b. DATE April 20/49	24c. NAME OF CEMETERY OR CREMATORY Valley Of Peace	24d. LOCATION (City, town, or county) (State) Quincey-----Illinois
--	------------------------------	---	---

DATE REC'D BY LOCAL REG. Apr-18-1949	REGISTRAR'S SIGNATURE Sidney J Gray	25. FUNERAL DIRECTOR'S SIGNATURE J. Leslie Sweeney	ADDRESS Marshall
---	--	---	-------------------------

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 4-26-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed J. Leslie Sweeney

Licensed Embalmer No. 3235

P. O. Address Marshall, W. Va.

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.