

FILED JUL 15, 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19379**

BIRTH NO. **33874-49** REG. DIST. NO. **144** PRIMARY REG. DIST. NO. **4234** Registrar's No. **30**

1. PLACE OF DEATH a. COUNTY Iron		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Washington	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ironton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Potosi	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 2	

3. NAME OF DECEASED (Type or Print) a. (First) Dennis Gene b. (Middle) Lowe c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) June 18 1949		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH June 17 1949	9. AGE (In years last birthday) 0 Months 0 Days 0	10. IF UNDER 1 YEAR 4 Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ironton Mo.	
13a. FATHER'S NAME James Lowe		13b. MOTHER'S MAIDEN NAME Gladys Brooks		14. NAME OF HUSBAND OR WIFE	

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. no		17. INFORMANT'S SIGNATURE OR NAME James Lowe, Potosi Mo. ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7625
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital atalactasis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c) 7 mos. gestation		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **June 17, 1949**, to **June 18, 1949**, that I last saw the deceased alive on **June 18, 1949**, and that death occurred at **1:30 A.**, from the causes and on the date stated above.

23a. SIGNATURE Brian Bull, M.D. (Degree or title)		23b. ADDRESS Ironton, Mo.		23c. DATE SIGNED 6-21-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 6-18-49		24c. NAME OF CEMETERY OR CREMATORY Des Arc		24d. LOCATION (City, town, or county) (State) Des Arc Mo.	
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DATE REC'D BY LOCAL REG. July 5, 1949		REGISTRAR'S SIGNATURE Miss Ann Jones 128		25. FUNERAL DIRECTOR'S SIGNATURE Walter Edward Haul ADDRESS	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

7-11-49

District Health Officer No. 4

District File Number 749-914

Date Filed _____

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 _____

Walter Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Ruby White

Licensed Embalmer No. 31012

P. O. Address Sanitarium

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.