

STANDARD CERTIFICATE OF DEATH

State File No. **39913**

FILED DEC 14 1949

BIRTH NO. _____ REG. DIST. NO. **337** PRIMARY REG. DIST. NO. **4496** Registrar's No. **106**

1. PLACE OF DEATH a. COUNTY Shelby		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Shelby	
b. CITY (If outside corporate limits, write RURAL and give township) Shelbyville		c. CITY (If outside corporate limits, write RURAL and give township) Shelbyville	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) Bell	c. (Last) Lowman	4. DATE OF DEATH (Month) (Day) (Year) Dec. 4 - 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb 15 - 1866	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 10 Days 19	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Retail	11. BIRTHPLACE (State or foreign country) Shelby County, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Samson B. Lowman	13b. MOTHER'S MAIDEN NAME Mary Wilson	14. NAME OF HUSBAND OR WIFE Ada Lowman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME Ada Lowman	ADDRESS Shelbyville Mo
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		19. INTERVAL BETWEEN ONSET AND DEATH a few minutes
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			331X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **Dec 4**, 1949, to **Dec 4**, 1949, that I last saw the deceased alive on **Dec 4**, 1949, and that death occurred at **9:35 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) P. G. Greider M.D.	23b. ADDRESS Shelbyville Mo	23c. DATE SIGNED 12-7-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec-6-49	24c. NAME OF CEMETERY OR CREMATORY C.O.O.R. Cemetery	24d. LOCATION (City, town, or county) (State) Shelbyville Mo
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DATE REC'D BY LOCAL REG. Dec-8-49	REGISTRAR'S SIGNATURE Ada Garrison	25. FUNERAL DIRECTOR'S SIGNATURE E.P. Thompson	ADDRESS Shelbyville Mo
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No. 300
 10.48
 102
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 WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 14 1953

RECEIVED

DEC 12

District Health Officer No.

District File Number 12-49

1953

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 _____

Myself

Student Embalmer No. _____

working under my personal supervision.

Signed *E. P. Thompson*

Signed _____
Student Embalmer

Licensed Embalmer No. 1632

P. O. Address Shelbyville, 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.