No. 300
10.48

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14747

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3960

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 7 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (Home) 2930 Dickson St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 2930 Dickson St.

2219
0

3. NAME OF DECEASED (Type or Print)
a. (First): Alice
b. (Middle):
c. (Last): LOWE

4. DATE OF DEATH (Month) 4 (Day) 29 (Year) 50

5. SEX: F. 3

6. COLOR OR RACE: Col

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow V

8. DATE OF BIRTH: 4-15-1897

9. AGE (In years last birthday): 53 a
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Columbus Miss

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Lum Reeves

13b. MOTHER'S MAIDEN NAME: Kattie Spry

14. NAME OF HUSBAND OR WIFE: John LOWE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): 710 (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT'S SIGNATURE OR NAME: Gus LOWE 2930 Dickson St.
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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: NONE

20. AUTOPSY? YES ☐ NO ☑

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) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? — 490 X

22. *I hereby certify that I attended the deceased from* 4-17-, 1950 *to* 4-29-, 1950, *that I last saw the deceased alive on* 4-28, 1950, *and that death occurred at* 8:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert M. Scott, M.D.

23b. ADDRESS: 3007 Easton Ave

23c. DATE SIGNED: 5-1-50

24a. BURIAL, CREMATION, REMOVAL (Specify): 11

24b. DATE: 5-4-50

24c. NAME OF CEMETERY OR CREMATORY: Columbus

24d. LOCATION (City, town, or county) (State): Columbus Miss.

DATE REC'D BY LOCAL REG.: MAY 2 1950

REGISTRAR'S SIGNATURE: J. B. Lasater

25. FUNERAL DIRECTOR'S SIGNATURE: George W. Bruce
ADDRESS: 4469 Washington Blvd

(Licensed Embalmer's Statement on Reverse Side)

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.

Student Embalmer No.....

Signed Arthur L. Herlihard

Signed.....
Student Embalmer

Licensed Embalmer No. 4221

P. O. Address 4049 St Jerdman

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.