

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5278

State File No.

FILED MAR 2 - 1953

BIRTH NO. _____ REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 4153 Registrar's No. 53-25

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

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lockwood Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>So. Greenfield Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>Smith twp rtl</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Bruce</u> b. (Middle) _____ c. (Last) <u>Lowrance</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-20-53</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>Sept. 1, 1884</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MOB RR</u>	11. BIRTHPLACE (State or foreign country) <u>carleton mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Robert W Lowrance</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary susan Taggart</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>522-07-0843</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Robert E. Lowrance</u>		ADDRESS <u>So. Greenfield Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>carcinoma of the stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity 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.		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) (Min.) _____	
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 <u>3-22-1951</u> , to <u>2-20-1953</u> , that I last saw the deceased alive on <u>2-20-1953</u> , and that death occurred at <u>5:45 p. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Max Heilbrunn</u>		23b. ADDRESS <u>Lockwood, Mo</u>	
(Degree or title) <u>M.D.</u>		23c. DATE SIGNED <u>2-20-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>2-21-53</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		24d. LOCATION (City, town, or county) (State) <u>Pueblo Colo.</u>	
DATE REC'D BY LOCAL REG. <u>2-21-53</u>		REGISTRAR'S SIGNATURE <u>J. C. Canade</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>W.R. Allison</u>		ADDRESS <u>Greenfield Mo.</u>	

MAR 31 1954

MAY 28 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *W. R. Allison*

Licensed Embalmer No. *4404*

P. O. Address *Greentield*

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.