

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37817**

FILED **NOV 6 - 1953** **75468**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **542** Registrar's No. **2577**

1. PLACE OF DEATH a. COUNTY St. Louis b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights c. LENGTH OF STAY (In this place) 2 Hrs. d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Overland Mo d. STREET ADDRESS (If rural, give location) 8934 Windom	
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3. NAME OF DECEASED a. (First) Infant b. (Middle) _____ c. (Last) Lowry			4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1953	
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Oct. 1, 1953		9. AGE (In years last birthday) 7 MONTHS _____ YEARS _____ IF UNDER 1 YEAR _____ IF UNDER 24 HRS. 2 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and State or Foreign Country) Richmond Heights, Mo.	

13a. FATHER'S NAME Milford Lowry	13b. MOTHER'S MAIDEN NAME Beatrice Piel	14. NAME OF HUSBAND OR WIFE NONE
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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 Milford Lowry ADDRESS 8934 Windom Ave.	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Engelbrecht blastosis fetalis 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 7700
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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) _____	
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 Oct. 1, 1953, to Oct 1, 1953, that I last saw the deceased alive on Oct 1, 1953, and that death occurred at 11:44 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Lee Lambert M.D.</i>	23b. ADDRESS 634 N. Grand	23c. DATE SIGNED 10/1/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 5, 1953	24c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. 10/2/53	REGISTRAR'S SIGNATURE <i>Herbert B. Lamb, M.D. Collins Funeral Home 10123 St. Charles Rd.</i>	25. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____
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(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student Ms. Embalming
Student Embalmer

Signed Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 10123 St. Charles

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.