

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38547

State File No. \_\_\_\_\_

10654

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR township) c. LENGTH OF STAY (in this place) <b>St Louis</b>		c. CITY OR TOWN <b>Saint Louis</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St John's Hospita;</b> 9 Hrs		e. STREET ADDRESS (If rural, give location) <b>6413 Oleatha</b> 14 <b>2149</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Mamie</b>	b. (Middle) <b>NMN</b>	c. (Last) <b>Lowenstein</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>12 4 1955</b>
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>7-3-1873</b>	9. AGE (In years last birthday) <b>82</b>	if UNDER 1 YEAR Months <b>7</b>	if UNDER 2 HRS. Hours <b>3</b>	if UNDER 2 HRS. Min. <b>2</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE RETURED</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Joseph Karel</b>	13b. MOTHER'S MAIDEN NAME <b>(Unknown) Homan</b>	14. NAME OF HUSBAND OR WIFE <b>Richard Lowenstein</b>
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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) <b>No None</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Egbert Ashe</b>	ADDRESS <b>6413 Oleatha St Louis, Mo</b>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 1/2</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>cerebral Thrombosis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Atherosclerosis</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>332x</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 March, 1952, to Dec 4, 1955, that I last saw the deceased alive on Dec 4, 1955, and that death occurred at 7:00pm m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>John G Matthews MD</b>	23b. ADDRESS <b>3707 Watson Rd</b>	23c. DATE SIGNED <b>12-5-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>12-7-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St Matthews Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>DEC 5 1955</b>	REGISTRAR'S SIGNATURE <b>J Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Hoffmeister Colonial Mortuary</b>	ADDRESS <b>St Louis, Mo 6464 Chippewa</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed *James C. Hoffner*

Licensed Embalmer No. 381

P. O. Address 78148

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.