

21970

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Koch FILED JUN 29 1956

318

1003

5538

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> 2209 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL #1.</u>		Length of stay in 1b	d. STREET ADDRESS <u>3225 N. Florissant</u>
3. NAME OF DECEASED (Type or print) First <u>PHILLIP</u> Middle Last <u>LOWELL</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1886</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		9b. AGE (In years last birthday) <u>70</u>	9c. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo</u>
13. FATHER'S NAME <u>John Lowell</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mice Carter</u>		Address <u>4141 Oregon</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung abscess</u>			INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchogenic carcinoma metastatic to regional nodes and liver</u> DUE TO (c) <u>162X</u>			<u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>5/14/56</u> to <u>6/8/56</u> and last saw her alive on <u>6/8/56</u> . Death occurred at <u>3:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Willard C. Schwartz, Jr.</u>		22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	
		22c. DATE SIGNED <u>6/8/56.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-13-1956</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>	
24. FUNERAL DIRECTOR <u>Chas Koch &amp; Son</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 11 1956</u>	
ADDRESS <u>3516 E. 14th</u>		26. REGISTRAR'S SIGNATURE <u>J. Charles Smith MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH

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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 *Ben E. Hoffmann*  
Licensed Embalmer No. *43*

P. O. Address *Albany*

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.