

FILED FEB 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 35

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>58</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kirksville Mo</u>		c. LENGTH OF STAY (in this place) <u>3 weeks</u>		c. CITY OR TOWN <u>LaPlata</u>		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>				STREET ADDRESS (If rural, give location) <u>061 1</u>			
3. NAME OF DECEASED a. (First) <u>Charles</u> b. (Middle) <u>Henry</u> c. (Last) <u>Low</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb-2-1957</u>				
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>5-8-1883</u>	
9. AGE (In years last birthday) <u>73</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>24</u>		10. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Forself</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Adair Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Frank Lowe</u>			13b. MOTHER'S MAIDEN NAME <u>Rebecca Munden</u>			14. NAME OF HUSBAND OR WIFE <u>Laura Lowe</u>	
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>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Blind LaMaster LaPlata Mo.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Auricular fibrillation</u> <u>Hypertensive cardiovascular disease</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Chronic glomerulo nephritis</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Cerebrovascular accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>years</u> <u>years</u> <u>years</u> <u>2 yrs. ago</u>	
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) m.		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>Jan. 13, 1957</u> , to <u>Feb. 2, 1957</u> , that I last saw the deceased alive on <u>Feb. 2, 1957</u> , and that death occurred at <u>2:30Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. D. McClure, D.O.</u>				23b. ADDRESS <u>Kirksville, Mo</u>		23c. DATE SIGNED <u>2/3/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Feb 3-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LaPlata Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>LaPlata Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-8-1957</u>		REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D. S. Christie LaPlata Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

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 *D. S. Christie*

Licensed Embalmer No. *1109*

P. O. Address *LaPlata*

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. . .