

FILED MAY 7 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

12981

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1912

Health,
& Welfare
Public
ServiceS. 300
1-56

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

Paul Lowell

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Lee's Summit Mo.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6251 Wornall		Length of stay in 1b 3 days		d. STREET ADDRESS (If outside, give location) 27 Hill Top Rd		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle M. Last BEDDOW				4. DATE OF DEATH Month 4 Day 21 Year 57			
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-29-1874		9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Apple City, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick McGillick				14. MOTHER'S MAIDEN NAME Mary McCune			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No XX		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Gladys Beddow, 10 E. Concord, KC Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) arteriosclerosis DUE TO (c) Senile Dementia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X							INTERVAL BETWEEN ONSET AND DEATH 24 hr yes 1 yr 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a. m. p. m. Month, Day, Year							
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 2/1/57 to 4/20/57 and last saw her alive on _____ Death occurred at 3:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Paul Lowell M.D.				22b. ADDRESS 711 W 46 St		22c. DATE SIGNED 4/22/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-24-57	23c. NAME OF CEMETERY OR CREMATORY Mayfield Cemetery		23d. LOCATION (City, town, or county) (State) Mayfield, So. Dakota		
24. FUNERAL DIRECTOR ADDRESS Wagner Funeral Home, N 6 Mo				25. DATE RECD. BY LOCAL REG. 4-23-57		26. REGISTRAR'S SIGNATURE neva minshall	

(Licensed Embalmer's Statement on Reverse Side)



Copy 2 - Record # 2
JE 1-5315

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 *Arthur R. Haun*.....

Licensed Embalmer No. *418*

P. O. Address *H. E. W.*

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.