

FILED DEC 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39297

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1312

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp.</u>		Length of stay in lb <u>37 Yrs</u>	d. STREET ADDRESS <u>2202 So. 14th</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <u>William</u> Middle <u>Stanley</u> Last <u>Lowinski</u>			Month <u>Nov.</u> Day <u>25</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1897</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>17</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School & Church</u>	11. BIRTHPLACE (City and state or country) <u>Saginaw, Mich.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony Lowinski</u>			14. MOTHER'S MAIDEN NAME <u>Mary Unknown</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. <u>491-09-7134</u>	17. INFORMANT <u>Mrs W.S. Lowinski</u> Address <u>St. Joseph, Mo. 2202 So. 14th</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>Lobar pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
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? <u>YES</u> <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 _____ 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>11/24/57</u> to <u>11/25/57</u> and last saw her alive on <u>11/25/57</u> Death occurred at <u>2:40 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>Donald J. Stallard, M.D.</u>	22b. ADDRESS <u>902 E. Diamond</u>	22c. DATE SIGNED <u>11/26/57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-29-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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24. FUNERAL DIRECTOR <u>Herman Sidenfaden</u>	ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 2, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Robert Fulton</u>
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(Licensed Embalmer's Statement on Reverse Side)

Health,
& Welfare
Public
ServiceS. 300
v. 1-56

All 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

MEDICAL CERTIFICATION

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Dr. Holland

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.....
Robert H. Gable

Licensed Embalmer No. 3308

P. O. Address St. Joseph,

**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.**