

Health, Welfare, Public Service

300
1-56

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

FILED APR 28 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013056
STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 129

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		c. CITY OR TOWN Kirksville	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hospital		d. STREET ADDRESS 502 E. McPherson St.	
3. NAME OF DECEASED (Type or print) First Grove Middle F. Last Lowrance		4. DATE OF DEATH Month April Day 18 Year 1958	
5. SEX M O W	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tax Accountant		10b. KIND OF BUSINESS OR INDUSTRY Accounting	11. BIRTHPLACE (City and state or country) Adair county, Mo
13. FATHER'S NAME Walter Lowrance		14. MOTHER'S MAIDEN NAME Anna Bell Towles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No X		16. SOCIAL SECURITY NO. 490-18-4785 A	17. INFORMANT Address Mrs. Corda Lowrance, Kirksville, 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) Congestive Heart Failure			INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Circulatory Insufficiency			7 days
DUE TO (c) Uremia			Approx. 21 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostatic Hypertrophy			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.) 610X		
20c. TIME OF INJURY Hour 5:20 Month 3 Day 18 Year 1958			
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 March 3, 1958 to April 18, 1958 and last saw ^{her} him alive on April 18, '58 Death occurred at 5:20 a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Jack L. Amter</i> (Degree or title)		22b. ADDRESS Kirksville, Mo.	22c. DATE SIGNED Apr. 18/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/20/58	23c. NAME OF CEMETERY OR CREMATORY Refuge Cemetery	23d. LOCATION (City, town, or county) (State) Adair County, Mo.
24. FUNERAL DIRECTOR <i>Paul W. Riley</i>		25. DATE RECD. BY LOCAL REG. 4-18-1958	26. REGISTRAR'S SIGNATURE <i>Doris W. Ratliff</i>

(Licensed Embalmer's Statement on Reverse Side)

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 *George W. Davitt*
.....

Licensed Embalmer No. *49*

P. O. Address *Kipsaw*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.