

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018343

STATE FILE NUMBER

FILED MAY 23 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2321

300
1-57

3

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 Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Hosp. #2		Length of stay in lb Life	d. STREET ADDRESS (If outside, give location) 1728 Belleview
3. NAME OF DECEASED (Type or print) First Louise Middle Lowery Last Lowery		4. DATE OF DEATH Month May Day 4 Year 1958	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1956
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	IF UNDER 24 HRS. Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kansas city mo.
12. CITIZEN OF WHAT COUNTRY? U. S.		13a. FATHER'S NAME Prentis Lowery	
13b. MOTHER'S MAIDEN NAME Eudell Lowery Eaton		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Louise Lowery, 1728 Belleview		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Intracranial Hemorrhage			9360 23
DUE TO (c) Retroperitoneal hemorrhage Multiple Head Trauma			
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 checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) multiple blow on head Don't know	
20c. TIME OF INJURY Hour 3 Month 5 Day 3 Year 1958 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		123	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1749 Belleview 1312 Euclid	
20f. CITY, TOWN, OR LOCATION Kansas City, Jackson, MO		COUNTY Jackson	
20g. STATE MO		21. I attended the deceased from Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Deputy Coroner		22b. ADDRESS 1618 Lydia Ave	
22c. DATE SIGNED 5/5/58		22d. SIGNATURE New Minshall	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/7/58	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR Badeau, Appleton & Jones, K.C., Mo.		25. DATE RECD. BY LOCAL REG. 5-7-58	
26. REGISTRAR'S SIGNATURE New Minshall			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Items 18, 20a, 20b, 20c, 20d, 20e, 20f, 20g, 20h, 20i, 20j, 20k, 20l, 20m, 20n, 20o, 20p, 20q, 20r, 20s, 20t, 20u, 20v, 20w, 20x, 20y, 20z, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

L. M. Tillman

All diseases in Part I must be causally related.

8887

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1312 2/1/1

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 *Comelia G. Galvez P.O.*

Licensed Embalmer No. *4944*

P. O. Address *K.C., Mo.*

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.