

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24655-58-05455  
STATE FILE NUMBER 807

FILED AUG 4 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 807

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Meadville</b> 05800 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hosp. #2</b> Length of stay in lb <b>1 Yr. 2 Mo</b>		d. STREET ADDRESS (If outside, give location) <b>Peerson Rest Home</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>Jesse W. Lowther</b>			4. DATE OF DEATH Month Day Year <b>July 27, 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1871</b>
9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>10 25</b>	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Linn County, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>Mansfield Lowther</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Morrow</b>
14. NAME OF HUSBAND OR WIFE <b>Emma Joyce</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>None</b>
17. INFORMANT <b>E.S. Lowther</b>		Address <b>Brookfield, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arterio-Sclerosis Heart</b> DUE TO (c) <b>4200</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Brain Syndrome associated with Senile Brain Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <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 <b>Brookfield</b>		COUNTY <b>Missouri</b> STATE	
21. I attended the deceased from <b>July 22, 1958</b> to <b>July 27, 1958</b> and last saw her alive on <b>July 25, 1958</b> Death occurred at <b>July 27, 1958 4:25 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Torrey Thomas M.D.</b>		22b. ADDRESS <b>9. State Hosp 712 N. 2nd St No 2</b>	
22c. DATE SIGNED <b>7-27-58</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>7/27/58</b>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county) <b>Brookfield</b>		STATE <b>Missouri</b>	
24. FUNERAL DIRECTOR <b>Wheaton-Cowman</b> ADDRESS <b>314 E 10th St. Joseph, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>July 27, 1958</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

540

8958 807

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 *Eugene Wood* .....

Licensed Embalmer No. *3804* .....  
P. O. Address *59 1/2 10th St. Gary* .....

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.

*Removed to Hill Funeral Home*