

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038975

STATE FILE NUMBER 1318

FILED DEC 15 1958

Registration District No. 042 Primary Registration District No. 1000 Registrar's No.

S. 300
1-57

All diseases in Part I must be causally related. No symptoms will be listed.

MEDICAL CERTIFICATION
DR. M. E. BENTLEY
BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|---|-------------------------------|---|--|
| 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 OR TOWN <u>St. Joseph</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>112 E. Franklin</u> Length of stay in lb <u>19 mos.</u> | | d. STREET ADDRESS <u>112 E. Franklin</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>LOWE</u> Last <u>LOWE</u> | | | 4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1958</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 9, 1902</u> |
| 9. AGE (In years last birthday) <u>96</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General Counsel</u> | 11. BIRTHPLACE (City and state or country) <u>unknown</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>unknown</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Minnie Lowe</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>none</u> | 17. INFORMANT <u>W. B. Leonard</u> Address <u>St. Joseph, Mo.</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>asthma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Heart trouble</u> DUE TO (c) <u>unknown</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4344</u> | | | 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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> | | | |
| 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>12/5/58</u> to <u>12/7/58</u> and last saw her/him alive on <u>12/7/58</u> Death occurred at <u>10:30 a.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>J. E. Remer M.D.</u> (Degree or title) | | 22b. ADDRESS <u>423 Main St. Joseph, Mo.</u> | 22c. DATE SIGNED <u>12/7/58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>Dec. 7, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>antioch cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Holt, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Fay Funeral Home Kansas, Mo.</u> ADDRESS <u> </u> | | 25. DATE RECD. BY SOCIAL REG. <u>Dec. 7, 1958</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u> |

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 *Lindell Jarman*

Licensed Embalmer No. *14589*
Excelsior Springs, Mo.
P. O. Address

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.