

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000042
STATE FILE NUMBER

FILED JAN 19 1959

Registration District No. 1 Primary Registration District No. Registrar's No. 12

300
-57

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 Novinger, Neniveh Twp		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Novinger, R. F. D. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION at family home		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Neniveh twp Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Graham Lowe			4. DATE OF DEATH Month Day Year Jan. 11, 1959		
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5. SEX M	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 Sept. 8, 1893	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Adair County, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME James Logan Lowe	13b. MOTHER'S MAIDEN NAME Alice Chapman	14. NAME OF HUSBAND OR WIFE Nellie May Anders Lowe
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, No unknown) (If yes, give war or dates of service) X	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Nellie May Lowe, Novinger, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion arterio-sclerotic heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) embolism DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1200		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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from July 1958 to Jan 11, 1959 and last saw him alive on Dec 1958 Death occurred at 8:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M.T. Gutensohn D.O.	22b. ADDRESS Kirksville, Mo.	22c. DATE SIGNED 1-11-59
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23a. BURIAL, CREMATION, REMOVAL (specify) Burial	23b. DATE 1/13/59	23c. NAME OF CEMETERY OR CREMATORY Maple Hills Cemetery	23d. LOCATION (City, town, or county) (State) Kirksville, Mo.
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24. FUNERAL DIRECTOR Paul R. [Signature] ADDRESS Kirksville, Mo.	25. DATE RECD. BY LOCAL REG. 1-12-1959	26. REGISTRAR'S SIGNATURE Doris W. Ratliff
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(Licensed Embalmer's Statement on Reverse Side)

M.T. GUTENSOHN D.O.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS OCT 13 1959

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. Davall*

Licensed Embalmer No. *4799*
P. O. Address *Kirksville, N*

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.