

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002370

STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 11

Health,  
Welfare  
Public  
Service

300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before registration) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sedalia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Highlandville</b> <b>0800</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RT 3 Dresden Twnshp.</b>		Length of stay in 1b	d. STREET ADDRESS <b>None</b> (If outside, give location)
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>M.</b> Last <b>LOWE</b>		4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Shops</b>	9. AGE (In years last birthday) <b>73</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>Halstead, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>not obtainable</b>		13b. MOTHER'S MAIDEN NAME <b>not obtainable</b>	
14. NAME OF HUSBAND OR WIFE <b>Gladys Gossage Lowe</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>702-07-7221</b>		17. INFORMANT <b>Dr. Alvin L. Lowe, 901 West Third, Mo. Sedalia,</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>Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>0</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ASHD</b>			<b>15yr.</b>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>			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.) <b>ITEM 25 CORRECTED</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		BY AFFIDAVIT OF Registrar <b>1-19-59</b>	
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		COUNTY	STATE
21. I attended the deceased from <b>Aug - 1958</b> , to <b>Jan - 3-59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>Jan - 3-59</b> Death occurred at <b>4 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Alvin L. Lowe, M.D.</b> (Degree or title)		22b. ADDRESS <b>Sedalia Mo</b>	
22c. DATE SIGNED <b>1-4-59.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 7, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>
23d. LOCATION (City, town, or county) <b>Sedalia, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Thorne Ewing</b>		ADDRESS <b>Sedalia, Mo.</b>	25. DATE RECD. BY <b>1959</b> REG. <b>Jan 6 - 1959</b>
26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>			

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 *A. E. Baker* .....

Licensed Embalmer No. *2419* .....  
P. O. Address *Sedalia* .....

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.