

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008768

STATE FILE NUMBER

FILED MAR 25 1959

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 37

300
1-57

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1. PLACE OF DEATH a. COUNTY <u>Platte</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Liberty</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Liberty</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital give location) HOSPITAL OR INSTITUTION <u>200 F. Herzog</u>		Length of stay in <u>20 months</u>	d. STREET ADDRESS (If outside, give location) <u>14 Mass St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>D</u> Last <u>LOWRANCE</u>			4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>59</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5-1890</u>	9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>Graham Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>James Hughes</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Herdrit</u>		14. NAME OF HUSBAND OR WIFE <u>Ray B. Lowrance</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>no</u>	17. INFORMANT <u>Miss Ruby Lowrance - Liberty Mo</u> 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) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.		DUE TO (b) <u>stroke since that time</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition given in PART I (a) <u>600 bed cast 4 months</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.) <u>4201</u>		
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		STATE
21. I attended the deceased from <u>1954</u> to <u></u> and last saw her alive on <u>March 10-59</u> Death occurred at <u>9:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. J. Leadson</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Liberty Mo</u>		22c. DATE SIGNED <u>3/11/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Mar 13-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>		23d. LOCATION (City, town, or county) (State) <u>Liberty Mo.</u>
24. FUNERAL DIRECTOR <u>Church-Cramer Co.</u>		ADDRESS <u>Liberty Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-18-59</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Graham</u>

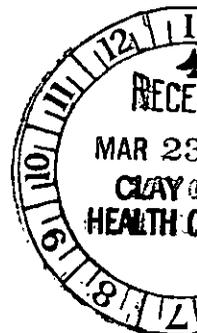
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MS NOV 1 1959

DEC 29 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 *Harold H. Smith*

Licensed Embalmer No. *4575*

P. O. Address *Liberty, 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.