

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000065
STATE FILE NUMBER

FILED VS. FEB. 8 1960 10

Primary Registration District No. 3002 Registrar's No. 37

| | | | | | | | | |
|--|--|---|--|---|-----------------------------------|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Audrain</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Mexico</u> | | Length of stay in lb <u>1 day</u> | | c. CITY OR TOWN <u>Wellsville</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS <u>RR #1</u> | | 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>HENRY</u> Last <u>LOWRY</u> | | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>1960</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 7, 1883</u> | | |
| 9. AGE (last birthday) <u>76</u> | | IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u> | | IF UNDER 24 HR Hours <u></u> Min. <u></u> | | 12. CITIZEN OF WHAT COUNTRY <u>U S A</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>general farming</u> | | 11. BIRTHPLACE (City and state or country) <u>Linns Mills Mo</u> | | |
| 13a. FATHER'S NAME <u>John Lowry</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Hetty Harvey</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mrs. Joseph Dickmann, Jonesburg Mo</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>488-42-7969</u> | | 17. INFORMANT <u>Mrs. Joseph Dickmann, Jonesburg Mo</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>coronary arteriosclerosis</u> DUE TO (c) <u>Essential Hypertension</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>several years</u> <u>2-3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If not related to the terminal disease condition given in PART I (a)) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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> Month, Day, Year <u></u> a.m. <u></u> p.m. <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 <u></u> STATE <u></u> | | |
| 21. I attended the deceased from <u>1-30-60</u> to <u>1-31-60</u> and last saw him alive on <u>1-31-60</u> Death occurred at <u>2/25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <u>Harold O. Langford M.D.</u> (Degree or title) | | | | 22b. ADDRESS <u>Superior Mo</u> | | 22c. DATE SIGNED <u>2-2-60</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>2/4/1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Jonesburg Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Jonesburg Mo</u> (State) | | |
| 24. FUNERAL DIRECTOR <u>K.B. Wells</u> ADDRESS <u>Wellsville, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>Feb 2-1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Howard F Myers

Licensed Embalmer No. 4494

P. O. Address Wellsville,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.