

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007706

AMENDED Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 292 STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY Buchanan
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in lb 2 days
 c. FULL NAME OF (IF NOT in hospital/ give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo. b. COUNTY Buchanan
 c. CITY OR TOWN St. Joseph Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 1523 S 25th Street Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Grace Inez Lowe

4. DATE OF DEATH Month Day Year
March 18 1961

5. SEX Female **6. COLOR OR RACE** White **7. Married** **Never Married**
Widowed **Divorced**

8. DATE OF BIRTH March 12 1887 **9. AGE (last birthday)** 79 IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife **10b. KIND OF BUSINESS OR INDUSTRY** Homemaker **11. BIRTHPLACE** (City and state or country) Putnam County Mo. **12. CITIZEN OF WHAT COUNTRY** U.S.A.

13a. FATHER'S NAME Marshall Lowellen **13b. MOTHER'S MAIDEN NAME** Harriett Terrell **14. NAME OF HUSBAND OR WIFE** Robert E. Lowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no **16. SOCIAL SECURITY NO.** **17. INFORMANT** Doel L. Henderson Address 1523 S 25th St. Joseph, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) massive cerebral hemorrhage
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerotic hypertensive cardiovascular disease
 DUE TO (c) _____
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but 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.
 Yes No Unknown

INTERVAL BETWEEN ONSET AND DEATH
24 hrs
3 hrs

19. WAS AUTOPSY PERFORMED? YES NO **20a. ACCIDENT** **SUICIDE** **HOMICIDE** **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK **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 8-5-58 to 3-18-61 and last saw her/him alive on 3-18-61
 Death occurred at 9:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R. L. Maginn MD **22b. ADDRESS** P.O. Bldg 216, St. Joseph, Mo **22c. DATE SIGNED** 3-20-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE** March 21 1961 **23c. NAME OF CEMETERY OR CREMATORY** Cox cemetery **23d. LOCATION** (City, town, or county) (State) Putnam County MO.

24. FUNERAL DIRECTOR Clarence E. Hixson ADDRESS **25. DATE RECD. BY LOCAL REG.** Mar. 23 1961 **26. REGISTRAR'S SIGNATURE** Mrs. Clark Standell

DATE AMENDED
 JUST-READ OF
 SHOULD READ
 BY AFFIDAVIT OF

DOCUMENT
 R.L. Maginn, M.D. Medical Certification

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 Clarence E. Hipson

Licensed Embalmer No. 5122

P. O. Address Lower, 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.