SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-042099

STATE FILE NUMBER

AMENDED

Registration District No. 314 Primary Registration District No. 4457 Registrar's No. 52

FILED NOV 29 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY St.Clair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Osceola
Length of stay in 1b I Da
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY St.Clair
c. CITY OR TOWN Vista
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First James Middle Albert Last Lowe
4. DATE OF DEATH Month Nov. Day II Year I96I
5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 3/29/I897
9. AGE (last birthday) 64
IF UNDER 1 YEAR Months Days
IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Texas
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME William H.Lowe
13b. MOTHER'S MAIDEN NAME Elizabeth Goad
14. NAME OF HUSBAND OR WIFE Annie Lowe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.#I
16. SOCIAL SECURITY NO.
17. INFORMANT Annie Lowe Address Vista Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
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

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 11-11-61 1 PM, to 11-11-61 2 15 and last saw her/him alive on 11-11-61
Death occurred at 2 15 PM. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Stanley D. Kerr M.D. (Degree or title)
22b. ADDRESS Osceola Mo
22c. DATE SIGNED 25 Nov 61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Nov.I4 I96I
23c. NAME OF CEMETERY OR CREMATORY Oak Ridge Memory
23d. LOCATION (City, town, or county) Independance (State) Mo.
24. FUNERAL DIRECTOR Goodrich Funeral Home ADDRESS Osceola Mo.
25. DATE RECD. BY LOCAL REG. 11-26-61
26. REGISTRAR'S SIGNATURE Ruth Beevers

(Licensed Embalmer's Statement on Reverse Side)

DEC 13 1961

NOV 29 1961

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 Paul Firestone

Licensed Embalmer No. 3990

P. O. Address Osceola, M

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.