

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028902

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7531**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 13 1962**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>ST LOUIS MO</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) <b>ST LOUIS MO</b>	a. STATE <b>MISSOURI</b>	b. COUNTY <b>ST LOUIS</b>
Length of stay in 1b <b>NONE</b>		c. CITY OR TOWN <b>WEBSTER GROVES</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS HOSPITAL P.O.A.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>628 N. ELM AVE</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>JOHN</b>	Middle <b>A</b>	Last <b>LOWE</b>	Month <b>JULY</b>	Day <b>29</b>	Year <b>1962</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</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>AUG 3, 1887</b>	9. AGE (last birthday) <b>74</b>	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) <b>CUSTOMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>	11. BIRTHPLACE (City and state or country) <b>CHATANOOGA TENN.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>JOHN LOWE SR</b>	13b. MOTHER'S MAIDEN NAME <b>REBECCA WADE</b>	14. NAME OF HUSBAND OR WIFE <b>JOSEPHINE LOWE</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES JULY 16, 1918 - JULY 1919</b>	16. INFORMANT <b>Josephine Lowe</b>	Address <b>628 N. Elm Ave</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Carcinoma of Pancreas.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>157X</b>	

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year p.m.	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 STATE
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21. I attended the deceased from _____ to _____ and last saw her alive on _____	
Death occurred at <b>6:30 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <b>Heleen L. Taylor, Coroner</b>	22b. ADDRESS <b>1300 Clark Ave.</b>	22c. DATE SIGNED <b>8-1-62</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <b>8-3-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>JEFF-BKS NAT'L CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST LOUIS CURRY MO</b>
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24. FUNERAL DIRECTOR <b>J. J. Vandell &amp; Sons</b>	ADDRESS <b>226 Euclid Ave</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 1 1962</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

91

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 *Herbert J. Paulee*

Licensed Embalmer No. 4243

P. O. Address 22 Euclid  
Wester Park 190th

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.