

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

=62-033214

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2490

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 11 1962

VS 300
Rev. 4/59

1 4092

2 214

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11 86-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Valley Park, Mo.</u> Length of stay in 1b <u>YRS.</u>		c. CITY OR TOWN <u>St. Louis,</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>Valley Park Nurse Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>formerly of 4953a Sutherland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OBADIAH LOWER</u> First Middle Last			4. DATE OF DEATH <u>Aug. 25, 1962</u> Month Day Year
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>Abt 77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. 15 yrs car insp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RR</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
13a. FATHER'S NAME <u>Irene Lower</u>		14. NAME OF HUSBAND OR WIFE <u>Josephine Lower</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)		17. INFORMANT <u>Hazel McFadon 7832 Wanda,</u> Address <u>St. Louis, Mo.</u>	
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>Generalized Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Peripheral Vascular Disease</u>			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 a.m. 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	STATE
21. I attended the deceased from <u>Jan. 7, 1959</u> to <u>Aug. 23, 1962</u> and last saw him alive on <u>Aug. 23, 1962</u> . Death occurred at <u>230 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Ernest O. Sanders, M.D.</u> (Degree or title)		22b. ADDRESS <u>1522 Cass Ave</u>	22c. DATE SIGNED <u>8-26-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	23b. DATE <u>8-27-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, Mo</u>
24. FUNERAL DIRECTOR <u>SOUTHERN FUNERAL HOME</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>8-27-62</u>	26. REGISTRAR'S SIGNATURE <u>John Murphy M.D.</u>

6322 So. GRAND ST. LOUIS MO (Licensed Embalmer's Statement on Reverse Side)

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 Samuel C. Hill

Licensed Embalmer No. 4347
P. O. Address 6322 So Grand

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.

Dr Sanders Lemoy Nursing Home