

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044548

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11622

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 7 1962

VS 300
Rev. 4/59

1

2 21/19

3

4 2

5 1

6

7 1

8 2

9

10

11

12 92-0

13

91

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
		<u>Saint Louis</u>		<u>17 years</u>		<u>Missouri</u>				<u>Saint Louis</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS		(If outside, give location)						Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
<u>DOA</u>		<u>Homer G. Phillip Hospital</u>		<u>3721 Cozen</u>															
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH Month - Day - Year							
			<u>John</u>						<u>Low Jr.</u>			<u>12 - 2 - 1962</u>							
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/>		Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.					
<u>Male</u>		<u>Colored</u>						<u>5-13-1899</u>		<u>63 years</u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY							
<u>Porter</u>								<u>Columbus, Mississippi</u>				<u>U. S. A.</u>							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE											
<u>John Lowe</u>				<u>Alice Reeves</u>				<u>Alice Lowe</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address											
<u>No</u>								<u>Mrs. Alice Lowe-3721 Cozen</u>											
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												INTERVAL BETWEEN ONSET AND DEATH							
<u>Coronary arteriosclerosis</u>												<u>Acute</u>							
Conditions, if any, which gave rise to above (a), stating the underlying cause last.																			
DUE TO (b)																			
DUE TO (c)												<u>4201</u>							
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									
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		COUNTY		STATE	
21. I attended the deceased from <u>1958</u> to <u>1962</u> and last saw ^{her} him alive on <u>4 mo ago</u> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <u>W. Earl Walker</u> (Degree or title)						22b. ADDRESS <u>118 S Central City</u>						22c. DATE SIGNED <u>4 Dec 62</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)							
<u>Burial</u>			<u>12-8-1962</u>			<u>Washington Park Cemetery</u>			<u>St. Louis County, Missouri</u>										
24. FUNERAL DIRECTOR ADDRESS						25. DATE RECD. BY LOCAL REG.			26. REGISTRAR'S SIGNATURE										
<u>Lowe's Funeral Home-2930 Dickson Street</u>						<u>DEC 4- 1962</u>			<u>Earl Smith, M.D.</u>										

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

Leroy E. Sannister

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

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.