

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045366

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

93
 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 62-79 STATE FILE NUMBER

FILED DEC 26 1962

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Walnut Grove</u> Length of stay in lb <u>Lifetime</u>		c. CITY OR TOWN <u>Walnut Grove</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 miles west of W.B.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4 miles W. of W.B.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT HADLEY LOWRY</u>			4. DATE OF DEATH Month Day Year <u>Dec 17-1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-10</u>
9. AGE (last birthday) <u>52</u>		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) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mill worker</u>	11. BIRTHPLACE (City and state or country) <u>Walnut Grove - Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Joseph Lowry</u>	
13b. MOTHER'S MAIDEN NAME <u>Amanda Hayes</u>		14. NAME OF HUSBAND OR WIFE <u>Wilma Lowry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWII</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Wilma Lowry - RR 1 - Walnut Grove - Mo.</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY occlusion</u> DUE TO (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</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 Month, Day, Year			
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>12-1-1959</u> to <u>12-17-62</u> and last saw her/him alive on <u>12-14-62</u> Death occurred at <u>3:20 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. R. Daws D.O.</u>		22b. ADDRESS <u>Walnut Grove Mo</u>	22c. DATE SIGNED <u>12-17-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-19-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wheeler Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Walnut Grove - Mo.</u>
24. FUNERAL DIRECTOR <u>Ernie Daniel - Walnut Grove - Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12/17/1962</u>	26. REGISTRAR'S SIGNATURE <u>J.C. Canada</u>

VS 300
Rev. 4/59

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2 0290
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12 90-2
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON
W. R. DAVIS, D.O.

2961 1962
DEC 27

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 Wayne L. Samuel

Licensed Embalmer No. 4702

P. O. Address Ashe Grove, N.C.

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.