MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Ripley

Township or Village or City: Jordan

Registration District No. 1090 — File No. 1 7290

Primary Registration District No. 5987 — Registered No. 1

(NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lucy Geneva McDowell

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	W	Single

DATE OF BIRTH: Feby (Month) 16 (Day), 1917 (Year)

AGE: ..... yrs. ..... mos. 2 ds. — If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

BIRTHPLACE (City or town, State or foreign country): Carter Co Mo

PARENTS
NAME OF FATHER: Joseph Elmer McDowell
BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
MAIDEN NAME OF MOTHER: Nellie A. Brooks
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. McDowell,

(ADDRESS) Grandin Mo

Filed Feb 28, 1917. M G Brooks
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feby (Month) 18 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Feby 16, 1917, to Feby 18, 1917, that I last saw her alive on 18, 1917, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Lagrippe with Convulsions

11 B

11 (Duration) ..... yrs. 10 mos. ..... ds.

Contributory (SECONDARY) .....

6 (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Watson M. D.

Feby 26, 1917 (Address) Grandin Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Macedonia — DATE OF BURIAL: Feb 19, 1917

UNDERTAKER: W E McKinney — ADDRESS: Grandin Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County .....

Township ..... or Village ..... or City .....

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(NO. ..... St.: ..... Ward)

[If death occurred in hospital or institution give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) .....

PARENTS

NAME OF FATHER .....

BIRTHPLACE OF FATHER (City or town, State or foreign country) .....

MAIDEN NAME OF MOTHER .....

BIRTHPLACE OF MOTHER (City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(ADDRESS) .....

Filed ..... 191..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ..... (Month) ..... (Day) ..... 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS

Every item of information CAUSE OF DEATH in plain t...

PLACE HISTORIAN ... OCCUPATION is very important.