MAR 23 1927

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

Do not use this space.

4363

1. PLACE OF DEATH

County: Dade — Registration District No.: 24 [illegible]

Township: North — Primary Registration District No.: 5832

City: ..... (No. ..... St. ..... Ward)

File No. .....

Registered No. .....

2. FULL NAME: Henry Laury

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: X

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March-17-1917

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
9	10	3	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Arcola Mo

PARENTS

10. NAME OF FATHER: Geo. H. Lowry

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Iowa

12. MAIDEN NAME OF MOTHER: Ida Underwood

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dade Co.

14. INFORMANT: W. F. Underwood
(Address): Arcola, Mo.

15. FILED: Mar 10 1927 Dr A. Higgins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 27 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1927, to Feb 27, 1927 that I last saw him alive on Feb 27, 1927, and that death occurred, on the date stated above, at 12 [illegible] m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

[illegible] Pneumonia Acute

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Dr A Higgins, M. D

, 19 (Address) Arcola Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, ~~CREMATION, OR REMOVAL~~: Gum Springs

DATE OF BURIAL: Feb. 28 1927

20. UNDERTAKER: J. W. Ward

ADDRESS: Greenfield Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.