

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

Do not use this space.

**1. PLACE OF DEATH**

County Demise

Registration District No. 681

Township

Primary Registration District No. 4388

City Cauthersville (No. ....)

File No. 25057 <sup>a</sup>

Registered No. 97

St. .... Ward)

**2. FULL NAME**

Mrs. Susan M. Fowler

(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. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Female

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)**

Widowed

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

Feb. 29, 1860

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>67</u>	<u>5</u>	<u>25</u>	

**8. OCCUPATION OF DECEASED**

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

(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) South Carolina

**10. NAME OF FATHER**

Alexander Blackadder

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) South Carolina

**12. MAIDEN NAME OF MOTHER**

Grabelle Clifton

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) South Carolina

**14.**

INFORMANT Black Fowler  
(Address) Cauthersville, Mo.

**15.**

FILED Aug. 18, 27 Ada Martin  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Aug. 17, 1927

**17. I HEREBY CERTIFY**, That I attended deceased from July 15

1927 to Aug. 17 1927

that I last saw him alive on Aug. 18 1927 and that death occurred, on the date stated above, at 12 midnight

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Myocarditis, Pneumonia,

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? .....

DATE OF .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) P. G. Weston, M. D.

Aug. 18, 1927 (Address) Cauthersville, 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** Memphis, Tenn. **DATE OF BURIAL** Aug. 19, 1927

**20. UNDERTAKER** Blytheville Ind. Co. Blytheville, Ark.

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.

28 1927

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Pennington Registration District No. 65-1 File No. ....  
 Township Caruthersville Primary Registration District No. 4388 Registered No. 97  
 City Caruthersville (No. ....) St. .... Ward .....

2. FULL NAME Mrs Susan M. Towler  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day,      hrs. or      min.

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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 60010, 1981 Ada Martin REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 17 19 27

17. I HEREBY CERTIFY That I attended deceased from ..... to ..... 19..... (that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Myocarditis, pneumonia

CONTRIBUTORY (SECONDARY) Broncho (duration) ..... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRIBUTED (duration) ..... yrs. .... mos. .... da.  
 IF NOT AT PLACE OF DEATH  
 DID AN OPERATION PRECEDE DEATH? NO  
 WAS THERE AN AUTOPSY? NO  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) ..... M. D.  
 , 19 (Address)

\*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
 19

20. UNDERTAKER ADDRESS

N. B.—very 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1750