JAN 5 1928

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

Do not use this space.

33977

1. PLACE OF DEATH

County Lawrence — Registration District No. 468 — File No.

Township — Primary Registration District No. 4281 — Registered No. 31

City Marionville (No. ..... St. ..... Ward)

2. FULL NAME Ida J Cowles

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

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: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edson C Cowles

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-2 1852

7. AGE 75 YEARS 8 MONTHS 14 DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Petersham
(STATE OR COUNTRY) Mass

PARENTS

10. NAME OF FATHER Samuel Taylor
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mass
12. MAIDEN NAME OF MOTHER Olivia K. Lincoln
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mass

14. INFORMANT Ruth E Tuggan
(Address) Marionville Mo.

15. FILED 11-17, 1927 R. Andrews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/15 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1927, to Nov. 16, 1927, that I last saw her alive on Nov. 16, 1927, and that death occurred, on the date stated above, at 6 o'clock p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility
50
162 (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Cancer of breast
(duration) 1 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptom

(Signed) F. W. Lester, M. D
, 19 (Address) Marionville 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: Marionville Cem. — DATE OF BURIAL: 11/17 1927

20. UNDERTAKER: R. C. Fite — ADDRESS: M-Ville 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.

[illegible] WITH UNFADING INK—THIS IS A PERMANENT RECORD