

N. B. - 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.

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

Do not use this space 4074

**1. PLACE OF DEATH**

County Merion  
 Township Sumner  
 City Merion (No. ....)

Registration District No. 553  
 Primary Registration District No. 6554

File No. ....  
 Registered No. 80  
 St. .... Ward

**2. FULL NAME**

Andy H. Sawery

(a) Residence No. .... St. .... Ward. ....  
 (Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 7 da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Male | **4. COLOR OR RACE** White | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single (write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** March 16 1869

**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
69 | 1 | 7

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
 (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)** Merion Co.

PARENTS

**10. NAME OF FATHER** Dr. S. Sawery

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

**12. MAIDEN NAME OF MOTHER** Combs

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

**14. INFORMANT (Address)** Thodore Wacke, Merion Mo

**15. FILED**..... 19.....

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** April 23rd 1928

**17. I HEREBY CERTIFY** That I attended deceased from April 15 1928 to April 23 1928  
 that I last saw him alive on April 23 1928; and that death occurred, on the date stated above, at 3:20 P.M.

**18. THE CAUSE OF DEATH WAS AS FOLLOWS:**  
Lobar Pneumonia

**19. CONTRIBUTORY (SECONDARY)** Asthma  
 (duration) 20 3/4 yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**20. DID AN OPERATION PRECEDE DEATH?** No DATE OF.....

**21. WAS THERE AN AUTOPSY?** No

**22. WHAT TEST CONFIRMED DIAGNOSIS?** None  
 (Signed) M. A. Smith M. D.  
 , 19 (Address) Lincolnville Iowa

\*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** Merion | **DATE OF BURIAL** April 25 1928

**20. UNDERTAKER** Frank Smith | **ADDRESS** Lincolnville Mo



**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 Merion Registration District No. 55-3 File No. \_\_\_\_\_  
 Township Summerset Primary Registration District No. 5754 Registered No. 20  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Andy D. Lowery  
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

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 May 10 1928 Josephine Ellis  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 23 1928

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

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) \_\_\_\_\_, 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.

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

20. UNDERTAKER ADDRESS

N. B. - Every item of information supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-124074