

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

Do not use this space.

5782

11-1920

County Cass
Towship Coldwater
City Drexel

Registration District No. 151
Primary Registration District No. 4085

File No. _____
Registered No. 3
St. _____ Ward _____

2. FULL NAME

Isabella Yesta 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sam'l N. Lowery

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr - 14 - 1841

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
86 9 29

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

9. BIRTHPLACE (CITY OR TOWN) Shelbyville
(STATE OR COUNTRY) Ind.

10. NAME OF FATHER Timothy Allison

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT Mrs. N. A. Pfook
(Address) Drexel Mo.

15. FILED Feb 14 1924 John S. Ruddy REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 13 1924

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1924 to Feb 13 1924, and that that I last saw her alive on Feb. 10 1924, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Occlusion.
(Sudden Death).

CONTRIBUTORY Chronic Bronchitis.
(SECONDARY) (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRIBUTED IF NOT AT PLACE OF DEATH? At Home

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____ WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) R. H. Stewart, M. D. , 19 (Address) Drexel 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 Orient Cemetery DATE OF BURIAL 2-15 1924
Shelbyville Mo

20. UNDERTAKER J. D. Hays ADDRESS Drexel Mo.

AR 11-1920
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.

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CAUSE OR DEATH in plain terms, so that it may be understood by the layman. It is especially important that the cause of death be stated in plain terms. It is especially important that the cause of death be stated in plain terms. It is especially important that the cause of death be stated in plain terms.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH Cass Registration District No. 151 File No. _____
 County _____ Primary Registration District No. 4083- Registered No. 3
 Township _____ City Drexel (No. _____ St. _____ Ward _____)
 2. FULL NAME Isabelle Vesta 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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) Apr - 14 - 1841

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
87 9 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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 2-14, 19 1929 John B. Berry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 19 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive 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. _____ ds.
 _____ (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) _____, 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 _____

SUPPLEMENTARY

PHYSICIANS & OCCUPATION is very imp. of it. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very imp. of it. be properly classified. Exact statement of OCCUPATION is very imp. of it. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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