

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

Do not use this space.

18623

1. PLACE OF DEATH

County Scotland Registration District No. 810 File No. _____
 Township Jeff Primary Registration District No. 4488 Registered No. 26
 City Memphis (No. _____) St. _____ Ward _____

2. FULL NAME

Margaret A. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 2 1933

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

17. I HEREBY CERTIFY, That I attended deceased from April 10 1933 to May 2 1933 that I last saw him alive on May 2 1933 and that death occurred, on the date stated above, at 1:30 p.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 23, 1856

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>76</u>	<u>6</u>	<u>7</u>		

Pneumonia of Stomach and Liver
46 (duration) Don't know yrs. mos. ds.
46 (duration) Don't know yrs. mos. ds.

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

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Marionetta, Ohio
 (STATE OR COUNTRY)

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

10. NAME OF FATHER Wilcomb Kennison

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

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

20. WAS THERE AN AUTOPSY? NO

12. MAIDEN NAME OF MOTHER Sarah Miller

WHAT TEST CONFIRMED DIAGNOSIS? _____

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

(Signed) W. H. Sanders, M. D.

14. INFORMANT Tom Lowery
 (Address) 6 Memphis

, 19 (Address) Memphis Mo

15. FILED 5-14-33 REGISTRAR

*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.

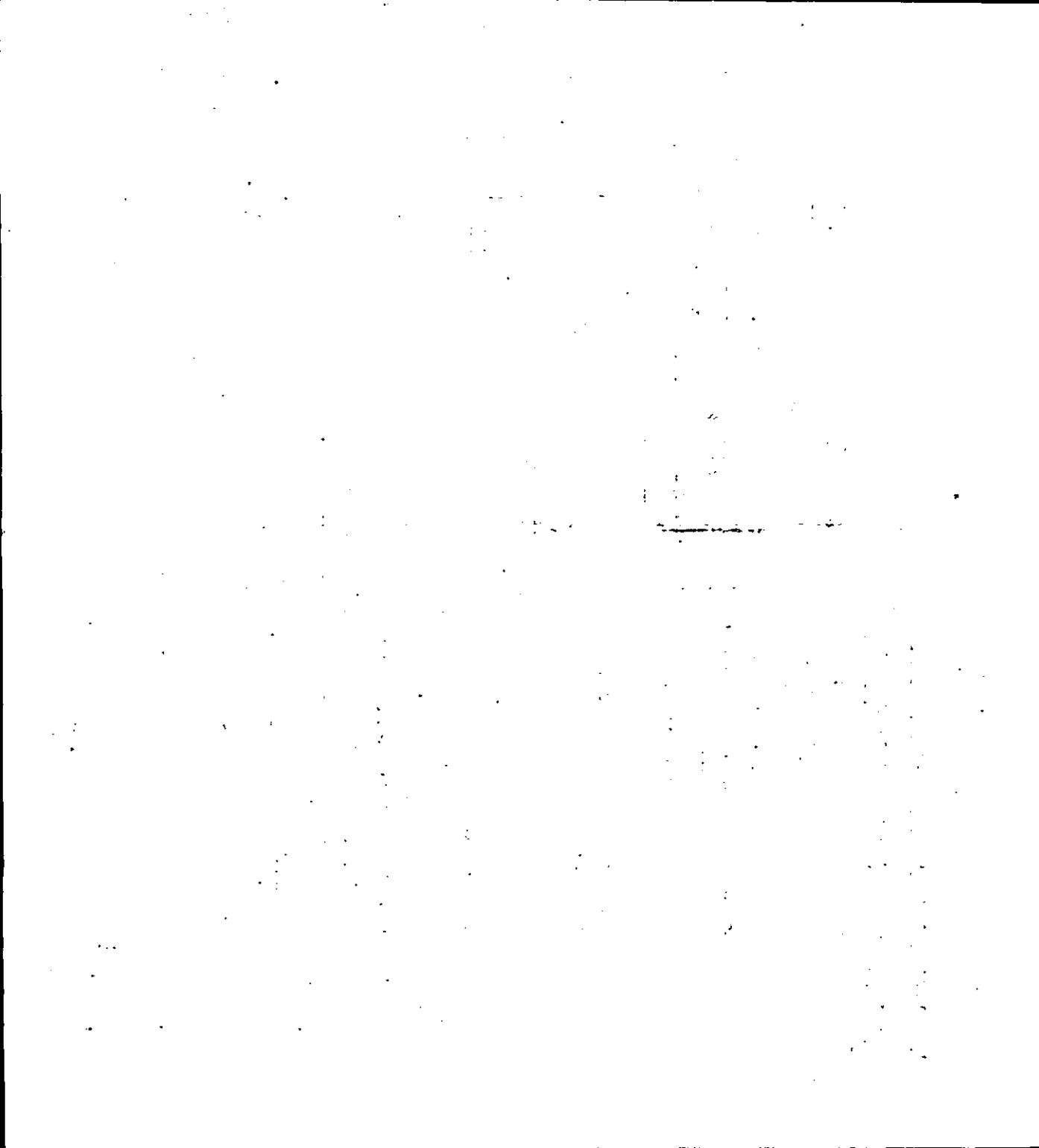
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Memphis cemetery DATE OF BURIAL 5/3/ 1933

20. UNDERTAKER W. H. Payne & Son ADDRESS Memphis

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.

JUN 24 1933

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2



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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Scotland
Township.....
City Marion (No.....)

Registration District No. 810
Primary Registration District No. 4488

File No.....
Registered No. 26
St. Ward)

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

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

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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 8-24-33

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 2 19 33

22. I HEREBY CERTIFY, That I attended deceased from to 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Business of stomach Date of onset

Other contributory causes of importance

Primary death
Don't know

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed)....., M. D.
(Address).....

Registrar

SUPPLEMENTARY

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 COMPLETED AS PRESCRIBED BY LAW.

5-18623