

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

1934 FEB 24 1236

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan
Township _____
City St. Joseph

Registration District No. _____
Primary Registration District No. 1001
(No. St. Joseph's Hospital)

85

File No. 3992
Registered No. 155
St. _____ Ward _____

2. FULL NAME

Wallace Lowrie

(a) Residence, No. 822 No. 2nd. St. St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Mary Elizabeth Lowrie

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr, 7, 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 10 0

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Collar maker, Wyeth Hdw. & Mfg. Co.

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) Sept, 1933 11. Total time (years) spent in this occupation 48

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) De Kalb, Ill.

13. NAME William Lowrie

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Gerald Lowrie
822 No. 2nd. St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Ashland Cemetery DATE Feb, 9, 1934

19. UNDERTAKER (ADDRESS) Walter McEachaffer
1302 Parson St, St. Joseph, Mo.

20. FILED 7 1934 John R. Bender
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb, 7, 1934

22. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1934 to Feb 7, 1934

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at 7.20 A.M.

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

Bronchopneumonia
107
Date of onset 1934

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis: Clinical Was there an autopsy? No

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? No
If so, specify _____

(Signed) W. J. Pearson, M. D.
(Address) St. Joseph, Mo.

