

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

Do not use this space.

MAR 24 1934

**1. PLACE OF DEATH**

County New Madrid Registration District No. 605  
Township Corn Primary Registration District No. 5809  
City (No. 4357) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 5847  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Leona F. Fowler

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 193-8-9

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
One Five 17

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) Mo

FATHER 13. NAME Robert Fowler

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

MOTHER 15. MAIDEN NAME Pearl Iva Cecil

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

17. INFORMANT (ADDRESS) James R Fowler

18. BURIAL, CREMATION, OR REMOVAL PLACE Parma DATE 2-17-34

19. UNDERTAKER (ADDRESS) J C Knight  
parma mo

20. FILED Feb 7 1934 Dr. Cowlished Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 6 1934

22. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1934, to Feb 6, 1934.

I last saw him alive on Feb 6, 1934. Death is said to have occurred on the date stated above, at 10 A.m.

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

Pneumonia Date of onset Feb 4

Other contributory causes of importance: Measles

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 Traylor Casket Co.  
(Signed) Malden (Address)

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.

