

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

Do not use this space.

7656

1. PLACE OF DEATH

County Adair Registration District No. 804
 Township Pock Primary Registration District No. J-803
 City Shelbott (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Greenleaf P.F.D. St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nona C. Lowen
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-16-1897
 7. AGE YEARS 36 MONTHS 9 DAYS 4 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Blacksmith
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Blacksmith Shop
 10. Date deceased last worked at this occupation (month and year) 1-4-34
 11. Total time (years) spent in this occupation 10

12. BIRTHPLACE (CITY OR TOWN) Trenton (STATE OR COUNTRY) Missouri
 13. NAME John M. Lowen
 14. BIRTHPLACE (CITY OR TOWN) Newark (STATE OR COUNTRY) Missouri
 15. MAIDEN NAME Mattie C. Guback
 16. BIRTHPLACE (CITY OR TOWN) Panthersburg (STATE OR COUNTRY) West Virginia
 17. INFORMANT Harry M. Lowen (ADDRESS) Willmathville Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Willmathville DATE 3-21- 1934
 19. UNDERTAKER Dee Riley (ADDRESS) Kimberly Mo.
 20. FILED April 2, 1934 Special Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 20, 1934
 22. I HEREBY CERTIFY, That I attended deceased from March 14, 1934, to March 20, 1934
 I last saw him alive on March 20, 1934 Death is said to have occurred on the date stated above, at 4 A. m.
 The principal cause of death and related causes of importance were as follows:

Pneumonia
1080 ✓
 Date of onset _____
 Other contributory causes of importance: _____

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? No
 If so, specify _____ (Signed) C. H. Van Osdol, M. D.
 (Address) _____

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Boyer
Township Park
City Boyer (No. 1)

Registration District No. 804
Primary Registration District No. 5803

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

2. FULL NAME

Charles F Louven

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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__

19. UNDERTAKER (ADDRESS)

20. FILED 19__

Ms O'Donnell
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 20 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, 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:

Infection
Bronchio
10/19

Other contributory causes of importance:

Date of onset

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) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-76576