

Jan FEB 19 1937

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

Do not use this space.

1. PLACE OF DEATH

County St. Francis

Registration District No. 773

File No. 2833

Township

Primary Registration District No. 4464

Registered No. 14

City Gasconade (No. 1)

St. _____ Ward)

2. FULL NAME James Low

(a) Residence, No. 101st Taylor St., _____ Ward.

Length of residence in city or town where death occurred 55 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 m. 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 11 - 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 2 9

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 90

10. Data deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 9

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

13. NAME James Low

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

15. MAIDEN NAME Isabelle Woods

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

17. INFORMANT Mrs. Emma Low (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Rock Hill Mo DATE 1-23

19. UNDERTAKER RICHARDSON FUNERAL HOME (ADDRESS) Gasconade Mo.

20. FILED Jan 22, 1937 W. F. Robinson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 20, 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 1935, to 1/20/1937, 1937. I last saw him alive on 1/20, 1937. Death is said to have occurred on the date stated above, at 10:35 a.m.

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

Uremic Toxemia Date of onset _____

Other contributory causes of importance: arteriosclerosis

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) Chas. E. Winters, M. D.

(Address) Gasconade Mo.

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.

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**MISSOURI STATE BOARD OF HEALTH
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1. PLACE OF DEATH

County St. Francois Registration District No. 773 File No. 2833
 Township _____ Primary Registration District No. 4464 Registered No. _____
 City Farmington (No. _____) St. _____ Ward _____

2. FULL NAME

James Low
 (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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS <u>79</u>	MONTHS <u>2</u>
	DAYS <u>9</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	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)		
FATHER	13. NAME	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
MOTHER	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 <u>March 27, 1937</u> <u>T.B.J. Robinson</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-20-1937

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

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

The principal cause of death and related causes of importance were as follows:
Uremic Poison
Chronic Interstitial Nephritis

Date of onset _____

Other contributory causes of importance:
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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) Chas. E. Winter, M. D.
 (Address) Farmington Mo

SUPERSEDED

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.

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