

REC'D AUG 11 1938

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

24780
Do not use this space.

1. PLACE OF DEATH
(a) County BUCHANAN Registration District No. 85
(b) Township _____ Primary Registration District No. 1001
(c) City ST. JOSEPH (d) Street No. ST. JOSEPH HOSPITAL Registered No. 741
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Jennie Lowe (LOWE) DUH
(a) Residence, No. St. Joseph Hospital, St. Bernard Mo (If nonresident, give city or town and State)

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 Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 12 1857
7. AGE YEARS 82 MONTHS 5 DAYS 29 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House
9. Industry or business in which work was done, as saw mill, bank, etc. Farm Home
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) Burnsboro
13. NAME John Lowe (LOWE)
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland
15. MAIDEN NAME Margaret Boyland
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT Joseph James Lowe (ADDRESS) St. Bernard Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Conception Mo DATE 7-18 1938
19. FUNERAL DIRECTOR (ADDRESS) W. A. ...
20. FILED July 17, 1938 H. J. ... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 16 1938
22. I HEREBY CERTIFY that I attended deceased from July 13 1938 to July 16 1938
I last saw her alive on July 16 1938. Death is said to have occurred on the date stated above, at 5:15 p.m.
The principal cause of death and related causes of importance were as follows:
Peri-neph abscess
Date of onset _____
Other contributory causes of importance:
Chf Myocard
Senility
Name of operation None Date of _____
What test confirmed diagnosis Chf 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) Dr. ... M. D.
(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.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No. or by, Registered Apprentice No.
working under my personal supervision.

Signed

Licensed Embalmer No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply with the above constitutes grounds for revocation of license.)