

DEC 24 1939

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

43915
Do not use this space.

1. PLACE OF DEATH
(a) County New Madrid Registration District No. 101
(b) Township Galbreath Primary Registration District No. 5-8-0-5
(c) City New Madrid (d) Street No. 212 St.
(e) Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Walter Farrell
(a) Residence, No. 212 St. (If nonresident, give city or town and State)

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 Anna Farrell
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-18-1891
7. AGE YEARS 47 MONTHS 1 DAYS 27 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as 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) Terry, Tenn
13. NAME J. M. Farrell
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Terry, Tenn
15. MAIDEN NAME Plummers' Pickens
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Opita
17. INFORMANT (ADDRESS) W. H. Farrell, 1041 S. Walton St., New Madrid, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Hopewell Tenn DATE 10/14/39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. S. ... Curdsville Mo
20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-16-39
22. I HEREBY CERTIFY, That I attended deceased from 9-1, 1939, to 10-16, 1939
I last saw him alive on 9-16, 1939. Death is said to have occurred on the date stated above, at 6:00 p. m.
The principal cause of death and related causes of importance were as follows:
1. Tuberculosis Pulmonary, chronic, 1930. bi tuberc
Date of onset
Other contributory causes of importance: 22
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) W. H. Jackson M. D.
(Address) New Madrid 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

Licensed Embalmer No. _____

P. O. Address _____

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.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

43913-
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 604
(b) Township Le Sieur Primary Registration District No. 5805 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Walter Lowell

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 Ella Lowell
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-18-1891
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
47 1 27
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
9. Industry or business in which work was done, as 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) Genoa Tenn

FATHER 13. NAME J. M. Lowell

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

MOTHER 15. MAIDEN NAME Plumina Lockens

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

17. INFORMANT (ADDRESS) B. H. Lowell Fulton Ky

18. BURIAL, CREMATION, OR REMOVAL PLACE Popwell Tenn DATE 10-17 1928

19. FUNERAL DIRECTOR (ADDRESS) H. S. Smith Caruthersville Mo.

20. FILED 2/23 1939 Wm O'Sauvan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-16 1938

22. I HEREBY CERTIFY, That I attended deceased from 9-1 to 10-16 1938

I last saw him alive on 10-16 1938. Death is said to have occurred on the date stated above, at 6 P. m.

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

Tuberculosis
Pulmonary chronic
Date of onset 1936

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? _____

If so, specify _____

(Signed) Wm M. Jackson, M. D.

(Address) New Madrid Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

RECEIVED

