

REC'D APR 15 1939

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

11028

Do not use this space.

1. PLACE OF DEATH **JACKSON**
- (a) County **JACKSON** Registration District No. **396**
- (b) Township **FT. OSAGE** Primary Registration District No. **4233** Registered No. _____
- (c) City **BUCKNER** (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
- (e) Length of residence in city or town where death occurred **3** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME **MRS. MAGGIE FLORENCE LOWERY**
- (a) Residence, No. **BUCKNER, MISSOURI (23 yrs)** (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F	4. COLOR OR RACE wh	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mr. L. J. Lowery				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 25 1873				
7. AGE	YEARS 65	MONTHS 9	DAYS 29	IF LESS THAN 1 day,hrs. ormin.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Keep house			
	9. Industry or business in which work was done, as saw mill, bank, etc. in her own 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) Missouri				
FATHER	13. NAME W.D. Brizendine			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri			
MOTHER	15. MAIDEN NAME not known			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known			

17. INFORMANT **L. J. Lowery**
(ADDRESS) **Buckner Mo.**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **Buckner Mo.** DATE **Mch. 16/39**

19. FUNERAL DIRECTOR (NAME) **V. M. Reppert**
(ADDRESS) **Buckner Mo. No. 2321**

20. FILED **Mar. 15, 1939** **John W. Robertson**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Mch. 14/39**

22. I HEREBY CERTIFY, That I attended deceased from **Feb. 24**, 19**38**, to **Mar 14**, 19**39**
I last saw her alive on **Mar 7**, 19**39**. Death is said to have occurred on the date stated above, at **1:40 P.M.**
The principal cause of death and related causes of importance were as follows:
Bright Disease

Date of onset **Personal Mark**

Other contributory causes of importance:
Chronic Bronchitis
Mitral regurgitation
Hypertension

Name of operation **None** Date of _____
What test confirmed diagnosis? **Chemical** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **X** Date of injury _____, 19____
Where did injury occur? **X** (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **X**
Nature of injury **X**

24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify _____
(Signed) **John W. Robertson**, M. D.
35 (Address) **Buckner, Mo.**

WRITE PLAINLY, WITH UNFADING INK...THIS IS A PERMANENT RECORD

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

FORM 1-11-1028

9/22/22

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,

V.M.Reppert

, or by

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

Signed *V.M. Reppert*

2321

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.

DEPT. OF HEALTH
DIVISION OF HEALTH SERVICES

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
DIVISION OF HEALTH SERVICES

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

11028
Do not use this space.

1. PLACE OF DEATH

- (a) County Jackson Registration District No. 396
(b) Township _____ Primary Registration District No. 4233 Registered No. _____
(c) City Buckner (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 Maggie Florence Lowery

- (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 F 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.
65 9 29

- OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED May 9 1939 John W. Robertson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-14-1939

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:

Bright's Disease
Chronic
181

Date of onset

Other contributory causes of importance:

Chronic Bronchitis
myocard degeneration
Hypertension

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) John W. Robertson M. D.

(Address) Buckner Mo.

item of inform. could be stated exactly. Properly classified. Exact statement of OCCUPATION is very important. REGISTERARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

1947-7 1949