

JUL 14 1939

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

22032
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 288
(b) Township Independence Primary Registration District No. 5406
(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

(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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-28-1937
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 6 1
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. at 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) Kennett Mo.
13. NAME Robert Lowe
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark
15. MAIDEN NAME Beneah Carter
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark
17. INFORMANT (ADDRESS) Robert Lowe
Kennett, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Dark Ridge DATE 6/30/39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Paul Salinas
Kennett, Mo.
20. FILED 7-5 19 39 Walter Dove
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 29 1939
22. I HEREBY CERTIFY, That I attended deceased from June 22 1939, to June 29 1939
I last saw him 7:00 pm alive on June 29 1939 Death is said to have occurred on the date stated above, at 9:30 am.

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

Colitis

Date of onset June 16

Other contributory causes of importance:

Name of operation N.A.M.E Date of
What test confirmed diagnosis? Exam 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?
If so, specify
(Signed) James B. Logan M. D.
(Address) Kennett, 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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X18605

RECEIVED

District Health Officer No. 3,

District File Number 739-435

Date Filed 7/10/39

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.