

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38849

Registration District No. 7

Primary Registration District No. 3001

Registrar's No. 266

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirkville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution  
416 North Florence Street 7  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
13 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair  
(c) City or town Kirkville  
(If outside city or town limits, write "RURAL")  
(d) Street No. 416 North Florence  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 52 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10  
year 1939 hour 2 minute 45 P. M.  
21. I hereby certify that I attended the deceased from 3/1, 1931, to Nov 10<sup>th</sup>, 1939  
that I last saw her alive on Nov 10<sup>th</sup>, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Myocardial Insufficiency  
(Chronic myocarditis)  
Due to in part carcinoma  
of pelvis and bladder  
Other conditions Chronic pyelitis  
(Include pregnancy within 3 months of death)

Duration  
Physician  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Margrete Lowrance  
3. (b) If veteran, name war no  
3. (c) Social Security No. no

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Walter Lowrance  
6. (c) Age of husband or wife if alive 73 years  
7. Birth date of deceased Jan 28 1865  
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 12  
If less than one day hr. min.

9. Birthplace New Castle England  
(City, town, or county) (State or foreign country)

10. Usual occupation Home U

11. Industry or business Domestic Home U

MOTHER FATHER { 12. Name John White  
13. Birthplace Scotland  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Mary Simpson  
15. Birthplace England  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Walter Lowrance

(b) Address 416 North Florence St.

17. (a) Burial (b) Date thereof 11-12-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Refused

18. (a) Signature of funeral director Dr. Riley

(b) Address Kirkville Mo

19. (a) Nov. 14, 1939 (b) Spencer L. Freeman  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations  
Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury  
23. Signature Geo. F. Sussel (M. D. or other)  
Address Kirkville Mo Date signed 11/14/39

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State  
of  
Md

RECEIVED

Public Health Officer No. 10

District File Number 12-39-2186

Date Filed DEC 11 1939

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 D. E. Riley

Licensed Embalmer No. 3908

P. O. Address Stinkwell MD

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  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

38849  
Do not use this space.

1. PLACE OF DEATH

(a) County Adair Registration District No. 4  
(b) Township ..... Primary Registration District No. 3001 Registered No. 266  
(c) City Xinville (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 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Margrete Rousance  
(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W  
(write the word)

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.
	<u>74</u>	<u>9</u>	<u>12</u>	

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1-9 Spencer L. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 10 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:

Myocardial Insufficiency (Date of onset) Continous on part of pelvis  
and bladder  
Cervix of uterus primary seat of cancer.

Name of operation H 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) Geo. F. Sneed, M. D.

(Address) Xinville

SUPPLEMENTARY

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

