

Registration District No. 347

Primary Registration District No. 2029

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal
 (c) Name of hospital or institution: Levering Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9 Months
 (Specify whether

In this community
years, months or days)3. (a) PRINT
FULL NAMEElmanetta
Auretta Lowrie (M.D.)3. (b) If veteran,
name war3. (c) Social Security
No.4. Sex Female5. Color or
race White6. (a) Single, widowed, married,
divorced Widowed

6. (b) Name of husband or wife

Thomas J. Lowrie6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased November 28, 1858
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

81213

hr. min

9. Birthplace

(City, town, or county)

Ohio

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name John Dillon13. Birthplace Unknown14. Maiden name Sarah Scholer15. Birthplace Unknown

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature Gertrude Lowrie(b) Address Ottumwa Iowa17. (a) Burial (b) Date thereof 2/13/40

(Burial, cremation, or removal)

Mt. Olivet

(c) Place: burial or cremation

18. (a) Signature of funeral director Crawford Smith(b) Address Hannibal, Missouri19. (a) 2/13/40

(Date received local registrar)

(b) [Signature]

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion(c) City or town Hannibal
(If outside city or town limits, write "RURAL")(d) Street No. 407 North Sixth
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 11
year 1940 hour 8 minute A.M. M.21. I hereby certify that I attended the deceased from
_____ 1935 to 2-11 1940that I last saw her alive on 2-10-40, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Exhaustion DurationSerulityDue to Fracture of leg!

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

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 [Signature] (M. D. or other) _____Address Hannibal Mo Date signed _____

1942

STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

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 Joseph J. Marsh
Licensed Embalmer No. 3932

P. O. Address Hannibal Missouri

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7328**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. **55-**

1. PLACE OF DEATH:

(a) County **Marion**

(b) City or town **Hannibal**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Elmanetta Louvie**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **81** Months **2** Days **13** If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month **7** day **11** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Senility**

Due to **Fracture of leg**

Due to **Fall in home**

Other conditions _____ (Include pregnancy within 5 months of death)

Major findings: Of operations **no** Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accident Fall**

(b) Date of occurrence **July 1939**

(c) Where did injury occur? **Hannibal Marion MO** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **home**

While at work? **no** (Specify type of place) (c) Means of injury _____

23. Signature **W. Hardisty** (M. D. or other)

Address **Hannibal** Date signed _____

Duration **6 yrs 6 mo**

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

