

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **11019**Registration District No. **320**Primary Registration District No. **5473**

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH

- (a) County Greene Clinton Franklin  
(b) City or town Springfield Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
RFD # 6  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Life years, months or days)

8. (a) PRINT FULL NAME Vernie May Lowery, Low

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Dick Lowery 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased Feb - 18 - 1889  
(Month) (Day) (Year)8. AGE: Years 51 Months 14 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Willard Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation housewife11. Industry or business housekeeping12. Name Henry S. Grant13. Birthplace Willard, Mo  
(City, town, or county) (State or foreign country)14. Maiden name Maude Smith15. Birthplace Cave Spring, Mo  
(City, town, or county) (State or foreign country)16. (a) Informant Dick Lowery(b) Address Springfield, Mo R617. (a) Burial (b) Date thereof March 4 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mt. Pleasant18. (a) Signature of funeral director Wesley A. Brown(b) Address Walnut Grove, Mo.19. (a) Mr - 4 (b) Wesley A. Brown  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Greene  
(c) City or town Springfield, Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. RFD # 6  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21  
year 1940 hour 3 minute 15 P. M.21. I hereby certify that I attended the deceased from Jan 25 1940 to Jan 27 1940  
that I last saw her alive on Jan 27 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Extensive Squamous  
cell Carcinoma involving  
the Cervix, Vaginal wall &  
Clitoris, X-ray chest  
shows numerous pulmonary  
metastases  
Other conditions It was sent to Col. G. H. Hensley, Fulton, Mo.  
(Include pregnancy within 3 months of death)

Major findings: She was sent back Feb 21Of operations: \_\_\_\_\_  
Physician: \_\_\_\_\_  
Physician: \_\_\_\_\_  
Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

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

RECEIVED

Greene County Health Office,

County No. Number 40-4-8

Date Filed 4-17-40

48

1416 - Catalpa

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

*Gene A. Brown*

Licensed Embalmer No. 2664

P. O. Address Halvick, Tenn Mo.

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **11079**

Registration District No. **370**

Primary Registration District No. **2443**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Greene**  
(b) **Center** **Jus**  
(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

**Hernie May Louriey**

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 **M**

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 Months Days If less than one day  
**51 - 14** h. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **7**  
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 **Stenosis**  
**Squamous Cell Carcinoma**  
**involving Cervix Vaginal**  
**and Clitoris & Gray**  
**Chest shows numerous**  
**Pulmonary metastasis**

Other conditions (Include pregnancy within 3 months of death)  
**# N. M. D. - query of**

Major findings: **Conc. Hopt. #**

Of operations \_\_\_\_\_

Of autopsy **48**

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 **W. S. Sewell** (M. D. or other)

Address **Springfield** Date **Mar**

SUPPLEMENTAL

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1940

S-11019