

FILED JUL 17 1942

Registration District No. 1-23 128

Primary Registration District No. 5174A

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Apple Creek Township
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
(c) City or town Cat Ridge R.F.D. 16
(If outside city or town limits, write "RURAL")
(d) Street No. Apple Creek Township
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Cecil Leon Lowes

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

4. Sex M O 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years

7. Birth date of deceased February 19 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 0 hr. min.

9. Birthplace Cape Girardeau Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business

12. Name Unknown

13. Birthplace Unknown (State or foreign country)

14. Maiden name DOROTHY LOWES

15. Birthplace Cat Ridge Mo. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Dorothy Lowes

(b) Address Cat Ridge Route

17. (a) Burial (b) Date thereof 6/21/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brushy Cemetery

18. (a) Signature of funeral director McCombton

(b) Address Jackson Mo.

19. (a) 6-2(1)42 (b) J. Jackson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19
year 1942 hour 11 minute 05 P.M.

21. I hereby certify that I attended the deceased from
....., 19....., to Coroner Case, 19.....
that I last saw h..... alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death. Congenital Cyanosis

Due to Persistence of Foramen Ovale

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations. 157e

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 Coroner

23. Signature Dr. J. F. Sigmond (Physician)

Address Jackson, Mo. Date signed 6/21/42

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

RECEIVED

District Health OFFICER No. 4
District File Number 742-929
Date Filed 7-14-52

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..... *Thos. K. Allen*

Licensed Embalmer No. 4055

P. O. Address..... *gaskin*

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, fact should be so stated above.