

No. 2
6-1-41
17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15000

ED MAY 14 1949

State File No.

Registration District No. 247

Primary Registration District No. 5-838

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Newton

(b) City or town State City - Rural

(c) Name of hospital or institution: Berwick Hosp.

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ (Specify whether)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo.

(b) County Newton

(c) City or town Rural Berwick twp

(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Viance Lowe

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Deceased

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 1 1871

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>7</u>	<u>7</u>	hr. _____ min.

9. Birthplace Lee County Va.

(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Joseph Lowe

13. Birthplace Va.

(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace _____

(City, town, or county) (State or foreign country)

16. (a) Informant Fred Lowe

(b) Address Miami, Okla.

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 4-10-43

(Month) (Day) (Year)

(c) Place: burial or cremation Berwick Cemetery

18. (a) Signature of funeral director Victor O. Hainwiler

(b) Address Pierson City Mo.

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 8

year 43 hour 4:00 PM minute _____ P. M.

21. I hereby certify that I attended the deceased from 4-3

1943 to 4-8 1943

that I last saw him alive on 4-8 1943

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage 5 days

Due to advanced age

Due to _____

Other conditions none

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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)

Means of injury _____

23. Signature J. C. Palens (M. D. or other)

Address Franklin Mo. Date signed _____

1149

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

Date Received

File no. 543-91

MAY

5 1943

MAY 11 1943

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

me

Registered Apprentice No.

working under my personal supervision.

Signed

Richard C. Hummer

Licensed Embalmer No.

3822

P. O. Address

Spice City

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15000

Registration District No. 247

Primary Registration District No. 5838

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Rural
(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 William V. Lowe

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

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

8. AGE: Years 71 Months 3 Days 13 (If less than one day 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) (Burial, cremation, or removal)..... (b) Date thereof.....
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) Apr. 10 '43 (b) Paul Norwood
(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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 Day.....
Year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....;
that I have seen him/her alive on....., 19.....;
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

