S. No. 2
M—2-43
5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27804

FILED SEP 14 [redacted]

Registration District No. ____ Primary Registration District No. 3007 Registrar's No. 270

12 7 3

1. PLACE OF DEATH:

(a) County: Butler

(b) City or town: Poplar Bluff (If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution: 24 hrs (Specify whether years, months or days)

In this community: ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Butler 12

(c) City or town: Fisk (If outside city or town limits, write "RURAL") "

(d) Street No.: R-1 (If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No) /

If yes, name country: ____

3. (a) PRINT FULL NAME: MAUDE LOWERY

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: Ray Lowery

6. (c) Age of husband or wife if alive: 49 years

7. Birth date of deceased: July (Month) 23 (Day), 1892 (Year)

8. AGE: Years 51 Months 1 Days 8 If less than one day hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business: ____

FATHER
12. Name: A. F. Sutton
13. Birthplace: Wayne Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name: Anna Chilton
15. Birthplace: Wayne Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Minnie Greene
(b) Address: 881 Wachtel, St. Louis Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 2, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Ash Hill, Mo.

18. (a) Signature of funeral director: Black's Mortuary
(b) Address: Corning Ark.

19. (a) 9-3-43 (Date received local registrar) (b) Belle Kinney (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 31 year: 1943 hour: 1:30 minute: 30 M.

21. I hereby certify that I attended the deceased from 8-30, 1943, to 8-31, 1943, that I last saw him alive on 8-31, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Intestinal obstruction — Duration

Due to: Cause unknown

Due to: 122 hr

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

Major findings:
Of operations: Exploratory laparotomy
Of autopsy: Patient in delirium when seen, died shortly after

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury: ____

23. Signature: [illegible] (M. D. or other)
Address: Poplar Bluff Mo. Date signed: ____

9 2

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 943-1190
Date Filed 9-13-43

SEP 17 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, [redacted] .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Leslie D. Russell

Licensed Embalmer No. 3855

P. O. Address Corning, Ark.

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.