-5-43
-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 15 1944

Registration District No. 209

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3043

State File No. 7743

Registrar's No. 77

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:
St. Elizabeth 0
(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: 87

(a) State Missouri (b) County Ralls 0

(c) City or town Saverton 0
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Mrs. Lena May Lowe

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Female

5. Color or race White 1

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Samuel Sam Lowe

6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased October (Month) 27 (Day) 1877 (Year)

8. AGE:

Years	Months	Days	If less than one day
66	3	26	..... hr. ..... min.

9. Birthplace Saverton (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name Hiram Foster
13. Birthplace Pennsylvania (City, town, or county) (State or foreign country) 1

MOTHER
14. Maiden name Anna West
15. Birthplace Saverton (City, town, or county) Missouri (State or foreign country) 0

16. (a) Informant Samuel E. Lowe
(b) Address Saverton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (Month) (Day) (Year)
(c) Place: burial or cremation Grandview

18. (a) Signature of funeral director Wm M Smith
(b) Address 902 Broadway Hannibal

19. (a) 2/24/44 (Date received local registrar) (b) R W Connor (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Eebruary day 23
year 1944 hour 4:30 A. M. minute ..... M.

21. I hereby certify that I attended the deceased from Feb. 17-44, 19..., to Feb. 23, 1944
that I last saw her alive on Feb 22, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cholecystis with ruptured gall bladder Gall stone

Due to .....

Due to .....

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

Major findings:
Of operations .....

Of autopsy Yes

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

126

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 0

23. Signature A. B. Blue (M. D. ~~or other~~)
Address Hannibal Mo Date signed 2-23-44

1146

(Licensed Embalmer's Statement on Reverse Side)

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

George T. Bond, Registered Apprentice No. 350

working under my personal supervision.

Signed Wm. M. Smith

Licensed Embalmer No. 1204

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, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 77

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 6 days (Specify whether
In this community Life
years, months or days)

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

3. (a) PRINT FULL NAME Lena May Towe

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 years

7. Birth date of deceased Oct. 27 1877
(Month) (Day) (Year)

8. AGE: Years 66 Months 3 Days 26 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) Robt W Conna (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23
year 1944 hour minute M.

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

	Duration
Immediate cause of death	
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?
(Specify type of place)
While at work? (e) Means of injury

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

SUPPLEMENTARY

7743