

FILED JAN 20 1945

Registration District No. 77

Primary Registration District No. 3008

Registrar's No. 407

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital no 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr. 2 mo. 11 days
(Specify whether In this community 1 yr. 2 mo. 11 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis 14

(c) City or town Greenville
(If outside city or town limits, write "RURAL") 2

(d) Street No. R 7.
(If rural, give location)

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

3. (a) PRINT FULL NAME Nannie J Lowe

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 13 year 44 hour 20 minute A. M.

21. I hereby certify that I attended the deceased from Dec. 1, 1944, to Dec 13, 1944, that I last saw her alive on Dec 12, 1944 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white

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

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

7. Birth date of deceased: April 18, 1859
(Month) (Day) (Year)

Immediate cause of death Lobar Pneumonia

Due to Fractured Pelvis

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

8. AGE: Years 86 Months 7 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name N. O. Crawford

13. Birthplace U.S.
(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 Marlin J. Ream

(b) Address Warrensburg Mo

17. (a) Removal (b) Date thereof 12/13/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenville, Mo.

18. (a) Signature of funeral director Wallace General Home
(Specify type of place)

(b) Address Fulton Mo (R. 6, Brownsville) (c) Means of injury _____

19. (a) 12-18-1944 (b) Josie M. Crawford
(Date received local registrar) (Registrar's signature)

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? _____

23. Signature James Thomas (M. D. or other) _____

Address Fulton Mo Date signed 12/13/44

WRITE PLAINLY—USE UNFADING BLACK INK—WRITE A CENTIMETER

RECEIVED

District Health Officer No.

District File Number.....

Date Filed 1-19-45

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 Benjil C. Browning

Licensed Embalmer No. 2724

P. O. Address Horton Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. *47*

Primary Registration District No. *3008*

Registrar's No. *407*

1. PLACE OF DEATH:

(a) County *Callaway*
(b) City or town *Fulton*
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Nannie J. Low

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 *W*

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

7. Birth date of deceased. *April 18* (Month) (Day) (Year)

8. AGE: Years *86* Months *7* Days _____ (less than one day) 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)
(Burial, cremation, or removal) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *10* year *1944* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and the death occurred on the date and hour stated above. Immediate cause of death *Labor pneumonia* Duration _____

Due to _____
Due to *Fractured pelvis due to fall*
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) *accident*
(b) Date of occurrence *12-9-44*
(c) Where did injury occur? *Fulton Callaway Mo* (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? *State Hosp. Mo* (Specify type of place)
While at work? *work* (c) Means of injury *fractured Pelvis*
23. Signature *Forrest Thomas* (M. D. or other) _____
Address *Fulton Mo* Date signed *12/25/44*

SUPPLEMENTARY 3

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

State Hosp. - Mo

1850