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X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 10 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9812

Registration District No. 143

Primary Registration District No. 4232

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Howell County.

(b) City or town Willow Springs. Mo.
(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 Mo (b) County Howell

(c) City or town Willow Springs - Mo
(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 Lila Rosalee Lowe.

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 Baby. C

6. (b) Name of husband or wife .....

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

7. Birth date of deceased July (Month) 7th. (Day) 1944 (Year)

8. AGE: Years | Months 8. | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Howell County. (City, town, or county) Missouri. (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

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

MOTHER
14. Maiden name Ruby Green.
15. Birthplace Howell County. (City, town, or county) Missouri. (State or foreign country)

16. (a) Informant Mrs. Hobert Green (Mother)

(b) Address Willow Springs. Mo. (Rural)

17. (a) ~~Burial 45~~ (Burial, cremation, or removal) (b) Date thereof 4-1-45 (Month) (Day) (Year)

(c) Place: burial or cremation Burial Pine Grove Cemetery

18. (a) Signature of funeral director T. R. Burns

(b) Address Willow Springs, Mo

19. (a) 4-7-45 (Date received local registrar) (b) Nanetta Ferguson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30 year 1945 hour 10 minute 10a. M.

21. I hereby certify that I attended the deceased from March 30, 1945, to March 30, 1945, that I last saw her alive on March 30, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death acute fulminating blood stream infection of	
Due to unknown etiology.	6 hrs.
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 [signature] (M. D. ~~or other~~)

Address Willow Springs Mo. Date signed 4-5-45

385 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Distr... H... ...fficer No. 5,
Distr... 445177
Date Filed 7.9.45

JUN 9 1948

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 T R Burns, Sr.

Licensed Embalmer No. 1837

P. O. Address Willow Springs

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.

S. No. 2B
M—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. April

Registration District No. 143 Primary Registration District No. 4232 Registrar's No. 83

1. PLACE OF DEATH:

(a) County Howell

(b) City or town Willow Springs
(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 (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 Lila Rosalee Lowe

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 S

6. (b) Name of husband or wife

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

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

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

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

10. Usual occupation

11. Industry or business

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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30
year 1945 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.

Immediate cause of death

Due to Unknown

Due to Not accident

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 2100

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature C. F. Callihan (M. D. ~~or other~~)

Address Date signed 4/20/45

SUPPLEMENTARY

9812