

FILED MAR 16 1948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9531

Registrar's No. 48

Registration District No. 242

Primary Registration District No. 4361

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Canalou
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
(c) City or town Canalou 72
(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 _____

3. (a) PRINT FULL NAME BOBBY RAY LOWERY

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 19, 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Baby

11. Industry or business _____

MOTHER FATHER { 12. Name Robert Henry Lowery
13. Birthplace Cairo Ill
(City, town, or county) (State or foreign country)
14. Maiden name Mary Helen Sanders
15. Birthplace Canalou Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Robt H Lowery
(b) Address Canalou Mo

17. (a) Burial (b) Date thereof 1-24-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Welch Funeral Home

(b) Address Sikeston Mo
19. (a) 3-11-48 (b) Thomas M. Sheets
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23
year 1948 hour 12 minute 10 P. M.

21. I hereby certify that I attended the deceased from Jan 16 - 1948 to Jan 23 - 1948
that I last saw him alive on Jan 22 - 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Malaria

Due to _____
Due to _____

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

Major findings: Of operations 158
Of autopsy _____

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) _____ (e) Means of injury _____

23. Signature J. P. Brainerd (M. D. or other) _____
Address Essex, Mo Date signed 1-29-48

Duration

19
1/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Form No. 2,
District No. 348 350
Date Filed 3-11-48

MAR 19 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 Raymond Crews
Licensed Embalmer No. 3467
P. O. Address Seaton Mo

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.