

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25301

FILED AUG 7 1948

State File No.

Registration District No. 374

Primary Registration District No. 4547

Registrar's No. 22

## 1. PLACE OF DEATH:

- (a) County Worth  
(b) City or town Grant City  
(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 45 days (Specify whether)  
In this community 45 years  
years, months or days

3. (a) PRINT FULL NAME Georgia Lowry

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 widowed  
6. (b) Name of husband or wife S. Westley Lowry 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 5 1881  
(Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 17 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

- MOTHER FATHER { 12. Name Peter Gose Claypool  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Catherine Peck  
15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant James Claypool  
(b) Address Grant City, Mo.

17. (a) Burial (b) Date thereof 7-25-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Grant City Cemetery

18. (a) Signature of funeral director Arch C. Duffee  
(b) Address Grant City, Mo.

19. (a) July 27, 1948 (b) Letta E. Dawson  
(Date received local registrar) (Registrar's signature) 211

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Worth  
(c) City or town Grant City, Mo.  
(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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22  
year 1948 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from July 20 to July 22, 1948  
that I last saw her alive on July 21 and that death occurred on the date and hour stated above.  
Immediate cause of death Myocarditis  
Due to Arteriosclerosis  
Due to \_\_\_\_\_  
Other conditions Arteriosclerosis, Degenerative  
(Include pregnancy within 3 months of death)

- Duration 3 mo.  
Major findings: Arteriosclerosis  
Of operations no  
Of autopsy no

- 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) no  
(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? no

- While at work? no (Specify type of place)  
(e) Means of injury no

23. Signature James M. D. (M. D. or other)  
Address Grant City, Mo. Date signed 7-23-48

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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..... *Arch C. Dunfee*

Licensed Embalmer No..... *3252*

P. O. Address..... *Grant City, N.*

**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.**