

FILED FEB 7 1951

STANDARD CERTIFICATE OF DEATH

State File No. 1918

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 233 PRIMARY REG. DIST. NO. 4348 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Montgomery	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wellsville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wellsville	
d. FULL NAME OF HOSPITAL OR INSTITUTION New Addition		d. STREET ADDRESS (If rural, give location) New Addition	

3. NAME OF DECEASED (Type or Print)	a. (First) INEZ	b. (Middle) -	c. (Last) LOWRY	4. DATE OF DEATH (Month) (Day) (Year) Jan. 27 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Nov. 5 1876	9. AGE (In years last birthday) 74	10. MONTHS 2	11. DAYS 22	12. HOURS	13. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) State of Iowa	12. CITIZEN OF WHAT COUNTRY? U. S. A
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13a. FATHER'S NAME Don't know	13b. MOTHER'S MAIDEN NAME Don't know	14. NAME OF HUSBAND OR WIFE Noah Lowry
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME <i>Walter J. ...</i> ADDRESS <i>Wellsville, Missouri</i>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  4500
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Advance arteriosclerosis</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Stroke</i> DUE TO (c)		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from Jan 1, 1951, to Jan 27, 1951, that I last saw the deceased alive on Jan 27, 1951, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>Willie H. Waller</i>	(Degree or title)	23b. ADDRESS <i>Wellsville Mo</i>	23c. DATE SIGNED <i>1/31/51</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/30/51	24c. NAME OF CEMETERY OR CREMATORY Wellsville City Cem.	24d. LOCATION (City, town, or county) (State) Wellsville Montg. Mo
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DATE REC'D BY LOCAL REG. 1-30-51	REGISTRAR'S SIGNATURE <i>W. S. Roman</i>	425	25. FUNERAL DIRECTOR'S SIGNATURE <i>A. B. ...</i> ADDRESS <i>Wellsville Mo</i>
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(Licensee Embalmer's Statement on Reverse Side)

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

0700

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4  
FEB - 5 1951

OCT 4 1951

RECEIVED

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Signed A. B. Shields

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 1588

P. O. Address Stellville 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.