

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **4273**

FILED MAR 13 1952

BIRTH NO. _____		REG. DIST. NO. 62	PRIMARY REG. DIST. NO. 3241	Registrar's No. 9
1. PLACE OF DEATH a. COUNTY Cedar		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cedar		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural E. Madison		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural E. Madison 0203		
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If rural, give location) _____		
3. NAME OF DECEASED (Type or Print) Barbara		a. (First)	b. (Middle) Lowry	c. (Last)
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH Oct. 29 1865		9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months _____ Days _____
11. BIRTHPLACE (State or foreign country) Davenport, Iowa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Jacob Reedy		13b. MOTHER'S MAIDEN NAME Pauline Riche		14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mrs May Galyan Fair Play, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Auricular fibrillation		INTERVAL BETWEEN ONSET AND DEATH days
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic hypertension Cardiovascular disease DUE TO (c) _____		yes
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. 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) 443X
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 2-5 , 19 52 to 2-25 , 19 52 , that I last saw the deceased alive on 2-20 , 19 52 , and that death occurred at 5:15 pm., from the causes and on the date stated above.				
23a. SIGNATURE Wm B Pulliam		23b. ADDRESS Stockton Dr		23c. DATE SIGNED 3-1-52
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 2-27-1952		24c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery
		24d. LOCATION (City, town, or county) (State) Fair Play, Mo.		
DATE REC'D BY LOCAL REG. 3-10-52		REGISTRAR'S SIGNATURE Geneva Garrison 54-1		25. FUNERAL DIRECTOR'S SIGNATURE Barber, Edwin & Blue ADDRESS Fair Play, Mo

(Licensed Embalmer's Statement on Reverse Side)

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

200

S. No. 300
V. 10. 48

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Willard P. Ewing*.....

Licensed Embalmer No. *3092*.....

P. O. Address *Belvidere 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.