

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

(86) 25000  
State File No. ....

FILED JUL 25 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 276

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISS</u> b. COUNTY <u>COVINGTON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEMINARY</u>	
c. LENGTH OF STAY (in this place) <u>10 DAYS</u>		d. STREET ADDRESS (If rural, give location) <u>R # 2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S. Hiway #60 west of Skerton</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>JESSIE</u> c. (Last) <u>LOWERY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-8-55</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>DIVORCED</u>	
8. DATE OF BIRTH <u>9-4-1923</u>		9. AGE (In years last birthday) <u>32</u>		10. IF UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONST. BOILER</u>		11. BIRTHPLACE (State or foreign country) <u>MISS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>James J. LOWERY</u>		13b. MOTHER'S MAIDEN NAME <u>BERTHA MOONEY</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>127-28-0952</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. J. Lowery</u> ADDRESS <u>Seminary Rd.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ELECTROCUTION</u>		ANTECEDENT CAUSES		INSTANTANEOUS	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
		DUE TO (c) _____		9145	
		II. OTHER SIGNIFICANT CONDITIONS		49	
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"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hiway 60 W</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>SCOTT MO.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>7 8 55 15 P.M.</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>CONTACTED ELECTRICAL WIRE</u>	

22. I hereby certify that I attended the deceased from 7-8, 1955, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Andrew S. Smith MD</u>		23b. ADDRESS <u>Skerton Mo.</u>		23c. DATE SIGNED <u>7-13-55</u>	
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24a. BURIAL, CREMATION, REMOVAL <u>REMOVAL</u>		24b. DATE <u>7-10-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Covington Miss</u>	

DATE REC'D BY LOCAL REG. <u>July 15-55</u>		REGISTRAR'S SIGNATURE <u>Max Otto Hunter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Welsh Funeral Home - Skerton Mo.</u> ADDRESS _____	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

300  
48

DATE RECEIVED **JUL 18** 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 655-143

JUL 25 1955

SEP 20 1955

NOV 1 1956

**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

*Raymond Crews*

Licensed Embalmer No. 3467

P. O. Address. Sikeston 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.