DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17512

FILED MAY 26 1944

Registration District No. 1

Primary Registration District No. 1000

Registrar's No. 513

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1606 Beattie 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 25 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11

(c) City or town St Joseph 7
(If outside city or town limits, write "RURAL")

(d) Street No. 1606 Beattie
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Robert Lee McDowell

3. (b) If veteran, name war —

3. (c) Social Security No. .....

4. Sex Male

5. Color or race White 0

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Anna B.

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased May (Month) 31 (Day) 1868 (Year)

8. AGE:

Years	Months	Days	If less than one day
75	11	10	..... hr. ..... min.

9. Birthplace Buchanan Co (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Laborer

11. Industry or business .....

FATHER
12. Name William McDowell
13. Birthplace ..... (City, town, or county) Tenn 1 (State or foreign country)

MOTHER
14. Maiden name Celia
15. Birthplace ..... (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Mrs Flora Richardson
(b) Address St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-44 (Month) (Day) (Year)
(c) Place: burial or cremation #6 Cemetery

18. (a) Signature of funeral director Fleemon & Son Inc
(b) Address St Joseph, Mo.

19. (a) 5/12/44 (Date received local registrar) (b) Mrs. Helen [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 10
year 1944 hour 5 minute 15 P M.

21. I hereby certify that I attended the deceased from 4-28, 1944, to 5-10, 1944
that I last saw h..... alive on 5-10-, 1944;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Bronchial Pneumonia	
Due to	
Other conditions Uremia (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION
Of autopsy REQUESTED

PHYSICIAN
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) .....
(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)
While at work? ..... (e) Means of injury ?

23. Signature Will W Trow (M. D. or other) D.O.
Address 222 Logan Bldg Date signed 5/11/44

1377

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY

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 Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 513

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Robert Lee McDowell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 31 (Day) 1868 (Year)

8. AGE: Years 75 Months 11 Days 10 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia

Due to

Due to

Other conditions Uremia (Include pregnancy within 3 months of death) following chronic nephritis.

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

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)

(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)

While at work? Means of injury

23. Signature Neil N. Grove (M. D. or other) D.O.

Address 222 Lyons Date signed 5/31/44

SUPPLEMENTARY

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

17512