DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 6 1947

Registration District No. 239

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24911

Primary Registration District No. 5825

Registrar's No. 107

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Catron 3 mi North (Como Twp)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None.
In this community 27 yrs in State (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid 7
(c) City or town 3 mi N- of Catron
(If outside city or town limits, write "RURAL")
(d) Street No. ✓
(If rural, give location)
(e) If foreign born, how long in U. S. A.? No years.

3. (a) PRINT FULL NAME LAWSON-ROWE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M. 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Minnie Rowe

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased July (Month) 17 (Day) 1884 (Year)

8. AGE: Years 62 Months 11 Days 10 If less than one day ___ hr. ___ min.

9. Birthplace State of Miss. (City, town, or county) 1 (State or foreign country)

10. Usual occupation farming

11. Industry or business ✓

FATHER
12. Name James Rowe 1
13. Birthplace State of Georgia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Margaret Evans
15. Birthplace unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant's own signature Minnie Rowe 1
(b) Address Catron Mo

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7-13-47 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Catron Mo.

18. (a) Signature of funeral director Watkins Funeral Service
(b) Address Parma Mo.

19. (a) 7-9-47 (Date received local registrar) (b) Dr. Geo W Husted (Registrar's signature) 14

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1947 hour 3 minute 00 A M.

21. I hereby certify that I attended the deceased from July 7, 1947, to July 7, 1947, that I last saw him alive on July 7, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac hemorrhage	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 0

23. Signature Dr. Geo W Husted (M. D. or other)
Address Parma Date signed 7/9/47

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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RECEIVED
District Health Office No. 2,
District File Number 847-10-27
Date Filed 8-2-47

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 Lyman Steele

Licensed Embalmer No. 2476

P. O. Address Dexter 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, above space should be left blank.