28642-113 28642-36

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 28642-113

PLACE OF DEATH

County Barry Shoal Creek

Township ~~Wheaton~~ or Village or City ____ (NO. ____ St.: ____ Ward)

Registration District No. ~~608~~ 31 File No. ~~19~~ 41

Primary Registration District No. 5044 Registered No. 14

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mr. John Lamasney

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word)
Male	White	

DATE OF BIRTH no records (Month) (Day) (Year)

AGE about 96 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) ____

BIRTHPLACE (City or town, State or foreign country) Canada.

PARENTS
NAME OF FATHER Don't know.
BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know.
MAIDEN NAME OF MOTHER Don't know.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maud Kennedy

(ADDRESS) Peirce City Mo.

Filed ~~Sept 22~~ Oct 29, 1918 ~~L. N. Parnell~~ A. J. Clevenger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. (Month) 22nd (Day) 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from June 5, 1918, to ~~Sept~~ Aug 5, 1918, that I last saw him alive on July 31st, 1918, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows: Nephritis Chronic and Complications

131 (Duration) 170 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R. A. Prichard M. D.

9-22, 1918 (Address) Wheaton Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL Peirce City Mo. DATE OF BURIAL Sept 23, 1918

UNDERTAKER John Seufert. ADDRESS Peirce City Mo.

MISSOURI STATE BOARD OF HE
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City ..... (NO. ..... St.; ..... Ward) [If death hospital or give its N of street an

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day) ..... (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day

I HEREBY CERTIFY, that I attended dece

....., 191...., to.....

that I last saw h..... alive on.....

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos.

Contributory.....
(SECONDARY)

..... (Duration) ..... yrs. ..... mos.

(Signed).....

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent C (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS