LOCAL REGISTRAR'S RECORD—DO NOT TEAR [illegible] OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS 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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS 923
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Howell

Township Dry Creek

or

Village Pomona

or

City ..... (NO. ..... St.: ..... Ward)

Registration District No. 387

Primary Registration District No. 5540

File No. .....

Registered No. .....

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

2 FULL NAME Calvin C Lemen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May (Month) 3 (Day) 1848 (Year)

7 AGE 76 yrs. 8 mos. 10 ds.

If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Marion, Ill. [illegible]

PARENTS

10 NAME OF FATHER James A Lemen

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

12 MAIDEN NAME OF MOTHER Almeria Gaffield

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank McCall

(Address) Pomona Mo.

15 Filed Jan 20, 1926 A P Cottell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 13 (Day), 1926 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 27, 1925, to Jan 13, 1926, that I last saw him alive on Oct 31, 1925, and that death occurred, on the date stated above, at 10 Am.

The CAUSE OF DEATH* was as follows:

General Paresis

83

Probably Several Months (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

8 (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Cox M. D.

1-13- 1926 (Address) Pomona Mo

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

18 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 .....

FEB 23 1926

19 PLACE OF BURIAL OR REMOVAL Mt Sinai

DATE OF BURIAL Jan. 14, 1926

20 UNDERTAKER Family

ADDRESS

RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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

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

(NO. ....., ... St.; ..... Ward)

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

NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

.....yrs. ..... mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h.....alive on ....., 191.....,

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) .....M. D.

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

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

....., 191.....

20 UNDERTAKER

ADDRESS

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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