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

35230

1. PLACE OF DEATH
County Dallas — Registration District No. 242 — File No. 34
Township Grant — Primary Registration District No. 5335 — Registered No.
City Louisburg MO (No. ..... St. ..... Ward)

2. FULL NAME George L Lunsden
(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widowed
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Carrie D Lunsden
7. DATE OF BIRTH (MONTH, DAY AND YEAR): 3/1/1866
8. AGE: 66 YEARS — MONTHS: 8 — DAYS: 2 — If LESS than 1 day, ... hrs. or ..... min.
9. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....
BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Iowa
10. NAME OF FATHER: Thomas Lunsden
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Scotland
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Canada
INFORMANT: Jeanne Lunsden
(Address): Louisburg MO
FILED 11/3 1932 W E Gammon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 3rd 1932
17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1932, to Nov 2, 1932, that I last saw him alive on Nov 2, 1932, and that death occurred, on the date stated above, at 12 20 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS: Endocarditis
92B
92 (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) W E Gammon, M. D
, 19 (Address) Louisburg MO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Cridgington — DATE OF BURIAL: 11-3 1932
20. UNDERTAKER: C F Marsh — ADDRESS: Louisburg

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1. PLACE OF DEATH

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

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

City..... (No....., ...St. .....Ward

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. d

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.
that I last saw h..... alive on....., 19....., and
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, s
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL,
HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIA
20. UNDERTAKER	ADDRESS