

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

25190

Do not use this space.

1. PLA

AUG 24 1938

FATH

*allas
Berkeley
at Top*

Registration District No. *243*

Primary Registration District No. *6337*

Registered No. _____

(d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(e) residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

W.H. Lucas

(a) Residence, No. *Red Top mo.* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-5-1938*

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

22. I HEREBY CERTIFY, That I attended deceased from *ap* *1938* to *7/5* 19*38*
I last saw h. alive on *7/4* 19*38* Death is said to have occurred on the date stated above, at *11:30 a.m.*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 19-1862*

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *75 9 15*

Chor Myo carditis

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

93C
Other contributory causes of importance: *Arterio-Sclerosis.*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *mo.*

FATHER 13. NAME *Paul Lucas*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER 15. MAIDEN NAME *Jane Potter*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *Anna Lucas
Red Top mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Union Grove* DATE *7-6-38*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *L.B. Jones
Berkeley mo*

20. FILED *722* 1938 *Aug 9 11 Shenandoah* Local Registrar.

Name of operation *None* Date of *mo*
What test confirmed diagnosis? *Physicist* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify _____
(Signed) *Chas. Max. Ditch*, M. D.
(Address) *Springfield Mo.*

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

Clyde Montgomery

Licensed Embalmer No. *3597*

P. O. Address

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

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

25-190
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 243
 (b) Township Sherridan Primary Registration District No. 6337 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME WILLIAM HENRY Lucas

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-5-1938

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...
 I last saw h. alive on 19... Death is said to have occurred on the date stated above, at... m.
 The principal cause of death and related causes of importance were as follows:

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 9 15

Other contributory causes of importance:

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Date of onset

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

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) C. H. Max Fitch, M. D.
 (Address) Springfield Mo

LED 7-12 1938 Marion Sherridaker
 Local Registrar.

SUPPLEMENTARY

