

REC'D FEB 24 1939

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

2800

Do not use this space.

1. PLACE OF DEATH

(a) County LACLEDE Registration District No. 449
 (b) Township _____ Primary Registration District No. 4267 Registered No. _____
 (c) City LEBANON (d) Street No. WALLACE HOSPITAL St.
 (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

430 KATHRYN L. FLOYD
 (a) Residence, No. PLATO STAR AT LEBANON MO (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAR 21-1913

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hr. or min.
25 10 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
 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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LACLEDE CO. MO13. NAME Mrs. NANNIE HAWK14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LACLEDE CO. MO15. MAIDEN NAME NANNIE HAWK16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LACLEDE CO. MO17. INFORMANT (ADDRESS) Miss Will Duffey Lebanon Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Crem Hope DATE 1 1919. FUNERAL DIRECTOR (ADDRESS) Polignac Lebanon Mo20. FILED 1-31 1939 J. A. McCoub Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 26 193922. I HEREBY CERTIFY That I attended deceased from Jan 23, 1939, to Jan 26, 1939Last saw him alive on Jan 26, 1939. Death is said to have occurred on the date stated above, at 4:20 P.M.

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

Septicemia
~~Septicemia~~
Septicemia
 144 P. 39
 Date of onset 1/22

Other contributory causes of importance:

Picked up with pills on Sunday Morn. Septicemia set up

Name of operation _____ Date of _____
What test confirmed diagnosis Blood cultures 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 Picked up pills

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Polignac M. D.(Address) Lebanon

RECEIVED

District Health Officer No. 7,

District File Number 7-34-295

Date Filed 2-10-39

STATEMENT BY LICENSED EMBALMER

I, D. Bohner, Licensed Embalmer No. 1161

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed D. Bohner

Licensed Embalmer No. 1161

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

Exact statement of OCCURRING EXACTLY BY THE DISTRICT HEALTH OFFICER

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

2800
Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449
(b) Township Lebanon Primary Registration District No. 4269
(c) City Lebanon (d) Street No. _____ Registered No. _____
(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

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M (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.
25 10 1

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 _____

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

FATHER MOTHER

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

15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE New Hope DATE 1-28 - 1939

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 3-11-1939 J. A. McComb Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-26 1939

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:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____ (Signed) P. Thompson, M. D.

(Address) Lebanon, Mo.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

