

REC'D FEB 24 1939

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

2804
Do not use this space.

1. PLACE OF DEATH

(a) County LACLAN Registration District No. 449

(b) Township LEGANON Primary Registration District No. 5609

(c) City _____ (d) Street No. _____ Registered No. _____ St.

(e) _____ (f) How long in U. S., if of foreign birth? yrs. mos. ds. yrs. mos. ds.

2. PRINT FULL NAME 110 VICTORIA LASWELL

(a) Residence, No. _____ St. (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 (write the word) WIDOW

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APR. 30, 1863

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>75</u>	<u>7</u>	<u>3</u>	

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. Work

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) BOON-CO MO

FATHER

13. NAME NATHAN CHASE

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

MOTHER

15. MAIDEN NAME CYNTHIA A ALLEN

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

17. INFORMANT (ADDRESS) Mrs. Tim Todd

18. BURIAL, CREMATION, OR REMOVAL PLACE Dodson DATE Jan 39

19. FUNERAL DIRECTOR (ADDRESS) PALMER'S LEGANON, Mo.

20. FILED 1-3-39 Jam. Cone Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN 2, 1939

22. I HEREBY CERTIFY That I attended deceased Jan 2, 1939, 7:00 A.M.

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at 7:50 A.M.

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

Arteriosclerotic Heart Disease with acute failure

Other contributory causes of importance: Semility & Exhaustion.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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) Raylth Jenkins, M. D.

(Address) 404 Leganon, Mo.

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.

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RECEIVED

District Health Officer No. 71
District File Number 7-39-291
Date Filed 2-10-39

STATEMENT BY LICENSED EMBALMER

I, W. B. Palmer, 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. 1161

working under my personal supervision.

Signed W. B. Palmer

Licensed Embalmer No. 1161

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