

REC'D MAY 12 1939

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

14218
Do not use this space.

1. PLACE OF DEATH
 (a) County BOONE Registration District No. 79
 (b) Township _____ Primary Registration District No. 4047 Registered No. _____
 (c) City STURGEON (d) Street No. _____ 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 Lucy ~~Bohon~~ Hersman
 (a) Residence, No. Sturgeon, Mo. 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

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 17, 1858

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day,hra. ormin.
<u>80</u>	<u>10</u>	<u>11</u>	

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 28, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1939, to April 28, 1939, 1939
 I last saw her alive on July 27, 1938, 1938. Death is said to have occurred on the date stated above, at 2:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia
 Date of onset 4/26/39

Other contributory causes of importance:
Fr R hip
2-3-39

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lexington, Mo.

FATHER
 13. NAME James H. Lynch
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

MOTHER
 15. MAIDEN NAME Lucy Ann Bohon
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

17. INFORMANT (ADDRESS) Mrs. Jane Hutton, Johnsonville, Ill.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Mo. Ariz DATE April 30, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Barnes & Booth, Sturgeon, Mo.

20. FILED April 29, 1939 A. P. Booth Local Registrar.

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? no
 If so, specify _____
 (Signed) A. P. Booth, M. D.
 (Address) Sturgeon, 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.

X 10603

1942

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.....

W. C. Boothe....., Registered Apprentice No. 131
working under my personal supervision.

Signed Reuben Barnes
Licensed Embalmer No. 2025
P. O. Address Sturgeon, Mo.

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.)

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

Missouri State Board of Health
Department of Health
St. Louis, Mo.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Boone Registration District No. 79
 (b) Township _____ Primary Registration District No. 4047 Registered No. _____
 (c) City Sturgeon (d) Street No. _____ 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 Lucey Herman

(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wed
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-18, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

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

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
80 10 11

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

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

Hepatic pneumonia

9. Industry or business in which work was done, as saw mill, bank, etc.

Other contributory causes of importance:
Fractured Hip

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 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)

20. FILED _____, 19____

Local Registrar.

Name of operation Fracture Hip Date of _____

What test confirmed diagnosis? Wright's test positive Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, fall, or homicide Date of injury Feb 2, 1939

Where did injury occur? at her home

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Fell out of chair in home

Manner of injury _____

Nature of injury Fr. Hip, Inter. Capsular

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) A. R. McComas, M. D.

(Address) Sturgeon 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.

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

SUPPLEMENTARY

