DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32296

REC'D OCT 10 1939

Registration District No. 269 — Primary Registration District No. 5376 — Registrar's No. 5

1. PLACE OF DEATH:

(a) County Dent 2

(b) ~~City or town~~ Rural

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: XXX

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX (Specify whether

In this community about 25 years

years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County Dent

(c) City or town Rural

(If outside city or town limits, write "RURAL")

(d) Street No. XX (If rural, give location)

(e) If foreign born, how long in U. S. A.? XX years.

3. (a) PRINT FULL NAME Sonie J. Luster

3. (b) If veteran, name war XXX

3. (c) Social Security No. XX

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Hannah E. Hale

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Dec 13 (Month) (Day) 1871 (Year)

8. AGE: Years 67 Months 9 Days 2 If less than one day hr. min.

9. Birthplace Crawford Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation farmer

11. Industry or business XX

FATHER
12. Name Bart Luster 1
13. Birthplace XXXXXX (City, town, or county) Ky 9 (State or foreign country)

MOTHER
14. Maiden name Rose Smith
15. Birthplace XXX (City, town, or county) XX (State or foreign country)

16. (a) Informant's own signature Isaac Luster

(b) Address Bangert Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9/17.39 (Month) (Day) (Year)

(c) Place: burial or cremation Round Pond Com

18. (a) Signature of funeral director Carl K. Spencer

(b) Address Salem Mo

19. (a) Sept 16 (Date received local registrar) (b) Mrs Cora Bailey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15 year 1939 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from July 24, 1932 to Sep 15, 1939 that I last saw him alive on Aug 28, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Nephritis	4 yrs
Due to Rheumatism	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy no	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. G. Dillon (M. D. or other)

Address Salem Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

I X19311

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.

RECEIVED

District Health Officer No. 5,

District File Number 1039263

Date Filed 10 3 39

Signed Carl X. Spencer

Licensed Embalmer No. 2370

P. O. Address Salem, Mi.

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.