

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 44157  
Registrar's No. 28

Registration District No. 615 Primary Registration District No. 5817

1. PLACE OF DEATH:  
(a) County Newton  
(b) City or town Rural Marion  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community two weeks (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Newton  
(c) City or town Anderson Rt. 3 Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME Mrs Lou Lauderdale  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_  
4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife L. F. 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased Jan 8 1873  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 4  
year 1938 hour 7 minute 30 A. M.  
21. I hereby certify that I attended the deceased from Nov. 30, 1938, to Dec 4, 1938,  
that I last saw her alive on Nov. 30, 1938,  
and that death occurred on the date and hour stated above.  
Immediate cause of death Adriaticum Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
66 10 26 hr. min.  
9. Birthplace McDonald MO.  
(City, town, or county) (State or foreign country)  
10. Usual occupation House wife  
11. Industry or business \_\_\_\_\_  
12. Name John Stillons  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Leucht  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

MOTHER FATHER  
16. (a) Informant's own signature Mrs C. T. Willberg  
(b) Address Diamond Rt 1  
17. (a) Burial (b) Date thereof 12-6-38  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mayfield Cem  
18. (a) Signature of funeral director Lee O. Caswell  
(b) Address Pineville Mo 64155  
19. (a) Dec 6 1938 (b) Mrs. M. S. Chalaman  
(Date received local registrar) (Registrar's signature)

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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature R. F. Chatham (M. D. or other) \_\_\_\_\_  
Address Diamond Mo. Date signed Dec 4

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.

RECEIVED

Dis. & Health Officer No. 6,

District File Number 1010-27

Date Filed JAN 4 1940

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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 Lee O. Learnee

Licensed Embalmer No. 2740

P. O. Address Pineville, 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.