

FILED FEB 17 1949

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

1518

Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Registration District No. 15
(b) Township Empire Primary Registration District No. 5018 Registered No. 2
(c) City or Franklin (d) Street No. _____ St.
(e) Length of residence in city or town where death occurred 42 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 230 Nancy Ellen Lester **LESTER**
(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 (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-26-1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
90 0 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housework
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) Jan 9 1933 11. Total time (years) spent in this occupation _____

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

FATHER 13. NAME Thomas Henderson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Craig W. Lester
230 Nancy Ellen Lester

18. BURIAL, CREMATION, OR REMOVAL PLACE Flagston DATE 1-16 1949

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. J. Taggart
Spring City, Mo.

20. FILED Jan 24 1949 Mrs. E. L. Jeffers
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13 1940

22. I HEREBY CERTIFY That I attended deceased from Jan 9 1940, to Jan 12 1940
I last saw him alive on Jan 12 1940 Death is said to have occurred on the date stated above, at 6:30 a.m.
The principal cause of death and related causes of importance were as follows:

Pneumonia

Date of onset
1/9/40

Other contributory causes of importance:
fracture of head of right femur

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical 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) Arthur E. Rockwood, M.D.
(Address) Union Star, Mo.

1940
1-6
816/1

RECEIVED

District Health Officer No. 11,

District File Number 240-111

Date Filed FEB 18 1940

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.....

Bill Taggart

Licensed Embalmer No. 2563

P. O. Address *King City*

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

15-18 7
Do not use this space.

PLACE OF DEATH

(a) County Andrew Registration District No. 15-
(b) Township Empire Primary Registration District No. 5018 Registered No. _____
(c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. 19 How long in U. S., if of foreign birth? yrs. mos. ds. _____

2. PRINT FULL NAME Nancy Ellen Lertha Lester
(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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
96 0 18
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 13. NAME _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

MOTHER 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 319 19 1940 Walter E. Rockhold Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13 19 40

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:

Broncho Pneumonia
Fracture of head of right femur
Other contributory causes of importance _____
Date of onset _____

Name of operation _____ Date of _____

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

23. If death due to external causes (i.e. violence) all in place the following: Accident, suicide, or homicide _____ Date of _____

Was death due to _____
Bed ridden since Dec 26, 1933.
Specify whether injury occurred in industry, in home, or in public place _____

Manner of injury _____
due to fracture of right femur head.

Nature of injury _____

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

If so, specify _____

(Signed) Luther E. Rockhold M. D.

(Address) Union Star - Mo.

SUPPLEMENTARY

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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15-18
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1. PLACE OF DEATH

(a) County Andrew Registration District No. 15
(b) Township Empire Primary Registration District No. 5018 Registered No. 2
(c) City (d) Street No.
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(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

Nancy Ellen Lirth Lester
(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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Lester
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
90 1 18
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as law 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).....
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 DATE, 19.....
19. FUNERAL DIRECTOR (ADDRESS).....
20. FILED 19 Mrs E C Jafferis Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13, 1940
22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
I last saw him..... 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 Luther E Rockhold M.D.
(Signed) Union Star M.D.
(Address).....