

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

3359  
Do not use this space.

1. PLACE OF DEATH *Phelps* Registration District No. *677*  
 (a) County *Phelps* Primary Registration District No. *4493* Registered No. *5*  
 (b) Township *Rolla* or *Rolla* Street No. *McIntosh Hospital* St.  
 (c) City *Rolla* (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 *Evelyn McGregor Lauekner*  
 (a) Residence, No. *Rolla* St.  (if nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *married*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Guy Lauekner*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *4-6-1901*  
 7. AGE YEARS *38* MONTHS *8* DAYS *28* If LESS than 1 day, .....hra. or .....min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housewife*  
 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) *Crocker, Mo.* (STATE OR COUNTRY)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 11* 19*40*  
 22. I HEREBY CERTIFY That I attended deceased from *Dec 25* 19*39*, to *Jan 11* 19*40*  
 I last saw her alive on *Jan 11* 19*40*. Death is said to have occurred on the date stated above, at *5 P* m.  
 The principal cause of death and related causes of importance were as follows:  
*Embalism*  
 Date of onset  
 Other contributory causes of importance:

13. NAME *P.H. McGregor*  
 14. BIRTHPLACE (CITY OR TOWN) *Dixon, Mo.* (STATE OR COUNTRY)  
 15. MAIDEN NAME *Nettie Vaughan*  
 16. BIRTHPLACE (CITY OR TOWN) *Waynesville Mo.* (STATE OR COUNTRY)  
 17. INFORMANT *Guy Lauekner* (ADDRESS) *Rolla, Mo.*  
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Rolla, Mo.* DATE *1/7/40* 19  
 19. FUNERAL DIRECTOR (NAME) *Mrs. Harry McCaw* (ADDRESS) *Rolla, Mo.*  
 20. FILED *Jan 7* 19*40* *Jos. F. Ayers* Reg. 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? .....  
 If so, specify ..... (Signed) *Wm. H. McFarland* M. D.  
 (Address) *Rolla 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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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, ~~only~~.....

*R. J. McEw*

Registered Apprentice No. ....

~~working under my personal supervision.~~

RECEIVED

District Health Officer No. 5.

District File Number 240-236

Date Filed 2/6/40

Signed.....

*R. J. McEw*

Licensed Embalmer No. 3953

P. O. Address Rolla

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  
STANDARD CERTIFICATE OF DEATH

State File No. 23597

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Phelps Rolla  
(b) City or town Phelps Rolla  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: McFarland Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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 Evelyn M. G. Faulkner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 38 Months 8 Days 28 If less than one day \_\_\_\_\_ h. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal) \_\_\_\_\_

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jun, day 4 - 1940  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death embolism of the lung following abdominal surgery

Due to Surgery  
Due to Appendectomy 12/1

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations acute appendicitis  
Of autopsy \_\_\_\_\_

Duration  
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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Adney M. G. Faulkner (M.D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

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

MOTHER FATHER

S-3359