V. S. No. 2
M—11-10-39
Rev. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 5988

Registrar's No. 189

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

11
5
9

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 days (Specify whether

In this community 31 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits write "RURAL")

(d) Street No. 2506 Francis Street (If rural, give location)

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

3. (a) PRINT FULL NAME Laura Virginia Lucas

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Charles F.

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

7. Birth date of deceased April (Month) 27 (Day) 1869 (Year)

8. AGE: Years 70 Months 9 Days 20 If less than one day hr. min.

9. Birthplace Longwoods (City, town, or county) Maryland (State or foreign country)

10. Usual occupation Housework

11. Industry or business Own Home

FATHER
12. Name Charles Neil Willis
13. Birthplace Unknown (City, town, or county) Maryland (State or foreign country)

MOTHER
14. Maiden name Frances Todd
15. Birthplace Unknown (City, town, or county) Maryland (State or foreign country)

16. (a) Informant Dudley Willis

(b) Address 1416 North 22nd, St. Joseph, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Feb. 19, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora Cemetery St. Joseph, Missouri

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1302 Faraon, St. Joseph, Missouri

19. (a) Feb. 19 1940 (Date received local registrar) (b) H. J. Nettlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17 year 1940 hour 3 minute 5 a.M.

21. I hereby certify that I attended the deceased from Jan 10, 1940 to Feb. 17, 1940 that I last saw her alive on Feb 16, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemiplegia (left)	1 wk
Due to arterio Sclerosis	10 years
Due to	
Other conditions Fracture of Rt. Hip - (Include pregnancy within 3 months of death) (neck + femur)	4 wks

Major findings:
Of operations
Of autopsy none

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) no

(b) Date of occurrence

(c) Where did injury occur? no (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? no (e) Means of injury

23. Signature [signature] (M. D. ~~or other~~)

Address 825 Charles, St. Joseph Date signed 2/17/40

(Licensed Embalmer's Statement on Reverse Side)

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 W. H. Kelly

Licensed Embalmer No. Mo. 3946

P. O. Address St. Joseph, Missouri

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.

V. S. No. 2B
10M—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5988 7

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 189

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:
(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 Laura Virginia Lucas

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 wid

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 70 Months 9 Days 20 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 4/11/40 (Date received local registrar) (b) H. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 17
year 1940 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
Hemiplegia (left)
arteriosclerosis

Due to

Due to
Fracture of rt. Hip
neck of femur (Intracapsular).

Other conditions
(Include pregnancy within 3 months of death)
due to a fall on Jan. 19, 1940.

Major findings:
Of operations
Of autopsy

186 W
18

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) accident
(b) Date of occurrence Jan. 19, 1940.
(c) Where did injury occur? St. Joseph, Buchanan, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home
(Specify type of place)
While at work? (e) Means of injury fell

23. Signature J. G. Thompson (M. D. or other)
Address 825 Charles St Joseph Mo Date signed