

APR 23 1940

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

11748
Do not use this space.

1. PLACE OF DEATH

(a) County Monteague Registration District No. 571
 (b) Township Walden Primary Registration District No. 4335 Registered No. 16
 (c) City California (d) Street No. _____ St.
 (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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

550 Willard Daniel Lehman
 (a) Residence, No. California No. 11 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 4, 1922
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 2 9

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) California (STATE OR COUNTRY) Missouri

13. NAME Daniel P. Lehman

14. BIRTHPLACE (CITY OR TOWN) Ohio (STATE OR COUNTRY) 1

15. MAIDEN NAME Catherine Oesch

16. BIRTHPLACE (CITY OR TOWN) Dickroy Co., Missouri (STATE OR COUNTRY) 1

17. INFORMANT Austin Henry Lehman (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Bethel Memorial Cem. DATE 3-15-1940

19. FUNERAL DIRECTOR (NAME) J. W. Wilson & Son (ADDRESS) California, Mo.

20. FILED 3-14-40 H. P. Popejoy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 13, 1940
 22. I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1940 to Mar. 13, 1940
 I last saw him alive on Mar. 13, 1940 Death is said to have occurred on the date stated above, at 12 noon
 The principal cause of death and related causes of importance were as follows:

Thrombosis
 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 _____

(Signed) H. P. Popejoy Registrar
 504 (Address) California, Mo.

Date of onset Mar. 3-40

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

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..... *A. E. Wilson*

Licensed Embalmer No. *2357*

P. O. Address *California, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11748

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 371

Primary Registration District No. 4331

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Probleman
(b) City or town California
(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

Willard Daniel Lehman

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s
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 18 Months 2 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 Mar day 13
year 1948 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 uremia

Due to Perilytic? Parasympathetic Nerv
due to operation for spinal neoplasm at
Due to 2 years ago

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature W. J. Bonior M. D. (Other) _____
Address California _____

SUPPLEMENTAL

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

11748 (1940)