

Registration District No. 449

Primary Registration District No. 4267

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede 1
(b) City or town Lebanon
(c) Name of hospital or institution: Malace Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 weeks
(Specify whether

In this community
years, months or days) 6 1/2

3. (a) PRINT FULL NAME ANNA JANE GREGORY

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 m

6. (b) Name of husband or wife Lawrence 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased July 17 1906
(Month) (Day) (Year)

8. AGE: Years 33 Months 9 Days 3 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business 6

12. Name Luzie Reifner

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

14. Maiden name Rebecca McInure

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

16. (a) Informant's own signature Lawrence Gregory

(b) Address Decaturville

17. (a) burial (b) Date thereof April 2 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Myrtle Cemetery

18. (a) Signature of funeral director Bankson - Wooley

(b) Address Cambden, Mo

19. (a) 4-29-40 (b) Jamcoub
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cambden
(c) City or town Decaturville Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Near Ha Ha fork junction
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1940 hour 11 minute 15 AM

21. I hereby certify that I attended the deceased from Feb, 1940 to Apr 20, 1940
that I last saw h. or alive on Apr 19, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Burns 3rd Degree Duration 1.1940

Due to Down 43 3rd Degree
burns

Due to _____
Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 Feb 19 40
(c) Where did injury occur? Cambden Co Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
While at work? Yes (Specify type of place) (e) Means of injury Burns

23. Signature E. J. Bankson (M.D. or other)
Address Cambden Date signed 4-20-40

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

Rev. 5-17-39
1 x19911

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

Partially

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

Robert Bankson Wolery

Licensed Embalmer No. *2488*

P. O. Address *Camden, N.J.*

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.

RECEIVED

District Health Officer No. 7,

District File Number *5-40-17*

Date Filed *5-28-40*

151

6

40-27-2
1940
DISTRICT

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15283

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 449

Primary Registration District No. 4267

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(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)

3. (a) PRINT FULL NAME Anna Jane Gregory
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 33 Months 9 Days 3 If less than one day _____ 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) _____ (Registrar's signature)
(Date received local registrar)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 20
year 1940 hour _____ minute _____ M.

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

Immediate cause of death: Burn 3rd Degree
over body surface
Due to While preparing dinner
around water stove
Due to Drugs cough kt from
Wasserman
Other conditions _____
(include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
181
15

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 E. J. Claiborne (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTAL

