

FILED MAY 15 1946

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

16404  
Do not use this space.

1. PLACE OF DEATH  
(a) County Webster Registration District No. 901  
(b) Township West Dallas Primary Registration District No. 6210 Registered No. 67  
(c) City \_\_\_\_\_ (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Daniel Lester Jauer  
(a) Residence, No. Rogersville R.F.D. #3 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) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lucy C. Jauer  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 8, 1860  
7. AGE YEARS 79 MONTHS 4 DAYS 16 If LESS than 1 day, hrs. or min.  
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. Retired Farmer  
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) Illinois

FATHER 13. NAME Nathaniel Jauer

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

MOTHER 15. MAIDEN NAME White Head

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) Mrs. Charles Vandell Fordal, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Weather Valley DATE Apr. 28, 1946

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kelley and Furrell Rogersville, Mo.

20. FILED 4-30-46 J. C. Bassore Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 25, 1946

22. I HEREBY CERTIFY, That I attended deceased from April 24 to April 25, 1946. I last saw him alive on April 25, 1946. Death is said to have occurred on the date stated above, at 5:55 a.m.

The principal cause of death and related causes of importance were as follows:

Hypostatic Pneumonia Date of onset 4/24-46

Other contributory causes of importance:

Name of operation none Date of X

What test confirmed diagnosis? X Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? NO Date of injury X, 1946

Where did injury occur? Home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify \_\_\_\_\_

(Signed) J. C. Bassore, M. D.

819 (Address) Rogersville, 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.

RECEIVED

District Health Officer No. 6,

District File Number 540-1295

Date Filed MAY 13 1910

111 W

**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 K. K. Kelley

Licensed Embalmer No. 3334

P. O. Address Keyman me

**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. 16404

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 901

Primary Registration District No. 6210

Registrar's No. 67

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

1. PLACE OF DEATH:  
 (a) County Webster  
 (b) City or town West Dallas  
 (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 Daniel Dexter Tower  
 (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 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 79 Months 4 Days 16 If less than one day \_\_\_\_\_ 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) \_\_\_\_\_

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.

20. DATE OF DEATH: Month apr day 25  
 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death: Hypostatic pneumonia

Duration \_\_\_\_\_

Due to In answer to your request this was neither bronchial nor lobar pneumonia

Due to The diagnosis is correct

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

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy: 1118-

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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. H. Wade (M. D. or other) \_\_\_\_\_  
 Address Retzerville Mo signed \_\_\_\_\_

SUPPLEMENTARY

PHYSICIAN  
J. H. Wade M.D.

THE UNIVERSITY OF CHICAGO  
LIBRARY