

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

23058
Do not use this space.

1. PLACE OF DEATH 2

(a) County Vernon 0 Registration District No. 871

(b) Township Osage Primary Registration District No. 6155 Registered No. 13

(c) City _____ (d) Street No. _____ St.

(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 George W. Ludy

(a) Residence, No. Rice Hill, Mo. R. R. # 2 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 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) Dec-10-1871

7. AGE YEARS 68 MONTHS 6 DAYS 13 IF LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Stationary Engineer

9. Industry or business in which work was done, as saw mill, bank, etc. Coal Mine

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 25-

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri C

FATHER 13. NAME Melton Ludy C

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri G

MOTHER 15. MAIDEN NAME Mary Westfall I

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Elizabeth Goodwin
(ADDRESS) Rice Hill # 3

18. BURIAL, CREMATION, OR REMOVAL
PLACE Ball Twp. DATE June-26-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Paul R. Peasley
Rice Hill Mo.

20. FILED 6-28 1940 Thelma Wilson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 23 1940

22. I HEREBY CERTIFY That I attended deceased from March 11 1940 to June 20 1940

I last saw him alive on June 23 1940 Death is said to have occurred on the date stated above, at 8:00 p.m.

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

Pharyngeal Cancer

Metastatic Carcinoma

Other contributory causes of importance:

Pharynx

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) Charles J. Allen, M. D.
(Address) St. Louis, Mo.

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

I X16605

92a

RECEIVED
District Health Officer No. 7.
District File Number 7-40-1069
Date Filed 7-16-40

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 me
....., Registered Apprentice No.....
working under my personal supervision.

Signed J. Hudson Reavley
Licensed Embalmer No. 2730
P. O. Address Rich Hill 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. **23058**
13

Registration District No. **871**

Primary Registration District No. **6155**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Vernon**
(b) City or town **Orange**
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

George W. Lady

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex **M**

5. Color or race **W**

6. (a) Single, widower, married, divorced **X**

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 **68**

Months **6**

Days **13**

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) _____ (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) _____ (Date received local registrar)

(b) _____

(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.

MENTAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **13**
year **1970** 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 _____

Duration **Chronic myo Carditis mitral Insufficiency**

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

Major findings: **Myocarditis**
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) _____
(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) _____ (Means of injury)

23. Signature **Charles J. Allen** (M. D. or other) _____
Address **Rich Hill** _____

