

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27897**
Registrar's No. **18**

Registration District No. **160**

Primary Registration District No. **5102B**

1. PLACE OF DEATH:
(a) County **Bollinger**
(b) City or town **Lafin**
(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 **2**
In this community _____ years, months or days

3. (a) PRINT FULL NAME **Ida Johanna Ladewe 536**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Robert Ladewe** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **AUG, 30 1906**
(Month) (Day) (Year)

8. AGE: Years **34** Months **X** Days **X** If less than one day _____ hr. _____ min.

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

10. Usual occupation **House Keeper,**

11. Industry or business _____

MOTHER FATHER
12. Name **John Heman**
13. Birthplace **Leopold**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Hulshof**
15. Birthplace **Leopold,**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Sophia Elmer**
(b) Address **Leopold Mo.**

17. (a) **Burial** (b) Date thereof **9-2-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Leopold**

18. (a) Signature of funeral director **Robert Heman**
(b) Address **Lutesville, Mo. T. B. Heman**

19. (a) **9/10/40** (b) **William H. Newcomb**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Bollinger**
(c) City or town **Lafin Lawrence, Ind.**
(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 **Aug** day **28**
year **1940** hour **11:30** minute **P.M.**

21. I hereby certify that I attended the deceased from **Aug. 28 1940** to **8-28 1940**
that I last saw him alive on **28 Aug 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Ceas. h. (Coronary) 2/2**
Duration _____

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? **State**
(Specify type of place) (e) Means of injury _____

23. Signature **J. H. Heman** (M. D. or other) _____
Address _____ Date signed _____

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.

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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.....

working under my personal supervision.

me

Registered Apprentice No.....

Signed *J. E. Graham*

Licensed Embalmer No. *4010*

P. O. Address *Louisville, Ky*

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.

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STANDARD CERTIFICATE OF DEATH

State File No. **27897**
Registrar's No. **18**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **66**

Primary Registration District No. **5702B**

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

1. PLACE OF DEATH:
(a) County **Bellinger**
(b) City or town **Monroe, La.**
(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.....
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Ida Johanna Landewe**
(b) If veteran, name war.....
(c) Social Security No.....

4. Sex **F**
5. Color or race **w**
6. (a) Single, widowed, married, divorced **w**
6. (b) Name of husband or wife.....
6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years **34** Months Days 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) (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) **9-10-40** (Date received local registrar) (b) **Millie H. Van Amburgh** (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.

19. MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **30** 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.....

Malignant melanoma Epithelioma
Due to.....
Primary left leg - removed at maffs - metastasis over body
Other conditions..... (Include pregnancy within 3 months of death)
Major findings: Of operations **57**
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?
While at work?..... (Specify type of place) (e) Means of injury.....
Signature..... (M. D. or other)
Address..... Date signed.....

