

STANDARD CERTIFICATE OF DEATH

Registration District No. 283

Primary Registration District No. 5402

1. PLACE OF DEATH:

(a) County Dunklin  
 (b) City or town Cardwell  
 (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 (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dunklin  
 (c) City or town Cardwell  
 (d) Street No. \_\_\_\_\_  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME Dewitt W. Lanair

8. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race W 6. (a) ~~Single~~ married; married, divorced \_\_\_\_\_

(b) Name of husband or wife Estella Lanair 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July 13 1886  
 (Month) (Day) (Year) 66

8. AGE: Years 74 Months 3 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name D. L. Lanair

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

14. Maiden name Lara Johnson

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

16. (a) Informant's own signature Estella Lanair  
 (b) Address Cardwell Mo

17. (a) Cardwell (b) Date thereof 10-24-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cardwell

18. (a) Signature of funeral director W. S. Howard  
 (b) Address Cardwell Mo

19. (a) 11-7-40 (b) W. S. Howard  
 (Date received local registrar) (Registrar's signature)

MOTHER FATHER

1 XESSI

NOV 15 1940 35217

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23  
 year 1940 hour 1:30 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from July, 1940, to October, 1940;  
 that I last saw him alive on October 22, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac dilatation & hypertrophy years

Due to Anemia \_\_\_\_\_

Due to Chronic gastritis \_\_\_\_\_

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

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

Of autopsy \_\_\_\_\_

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?  
SI (Specify type of place) While at work? (a) Means of injury \_\_\_\_\_

23. Signature M. C. Glasgow (M. D. or other) \_\_\_\_\_  
 Address Cardwell, Missouri Date signed 10-23-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WHILE I REMAIN USE UNFADING BLACK INK—MAKE 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.

107-10

RECEIVED

District Health Officer No. 2,

District File Number 1140-169

Date Filed 11/13/40

**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.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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. **35-217**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **283**

Primary Registration District No. **4167**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:  
(a) County **Cardwell**  
(b) City or town **Cardwell**  
(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 **Dewitt W Lanier**

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 \_\_\_\_\_

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 **74** Months **3** Days **11** If less than one day \_\_\_\_\_ in \_\_\_\_\_ 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 \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(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 **10** day **23** year \_\_\_\_\_ 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 **Cardiac Dilatation**  
**Myocarditis**  
**anemia**

Due to **Chc Peritonitis**  
**due to lymphocytic**

Other conditions **Asplenia**  
(Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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 a (work)? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Means of injury)

23. Signature **M. C. Lanier** M. D. \_\_\_\_\_

Address **Cardwell Mo** Date signed \_\_\_\_\_

SUPPLEMENTARY

PHYSICIAN  
Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30217

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 283

Primary Registration District No. 467

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Cardwell  
(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 Dewitt W Lanier

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month 10 day 23  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Estelle Lanier

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

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

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

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>3</u>	<u>11</u>	h. _____ min.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

10. Usual occupation \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

(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? \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

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

19. (a) 11-7-40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Cardwell \_\_\_\_\_

SUPPLEMENTAL