DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

NOV 21 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36223

Registration District No. 757 Primary Registration District No. 3036 Registrar's No. 178

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

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One day (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 729 N. Benton Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Joseph Lackland
3. (b) If veteran, name war No
3. (c) Social Security No. 493-07-0024
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jacqueline Cooper
(c) Age of husband or wife if alive 54 years
7. Birth date of deceased December (Month) 7 (Day) 1883 (Year)

8. AGE: Years 56 Months 10 Days 6 If less than one day ____ hr. ____ min.

9. Birthplace Dennison (City, town, or county) Texas (State or foreign country)
10. Usual occupation Employment Agent
11. Industry or business American Car & Foundry
MOTHER FATHER
12. Name Joseph N. Lackland
13. Birthplace Washington (City, town, or county) Mo. (State or foreign country)
14. Maiden name Theodoshia Shore
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Mrs. Joseph Lackland
(b) Address 729 N. Benton Ave., St. Charles, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery, St. Charles, Mo.
18. (a) Signature of funeral director H. C. Dallmeyer & Son Co.
(b) Address 800 N. Second, St. Charles, Mo.
19. (a) 10-15-40 (Date received local registrar) (b) Clarence A. Nessler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13 year 1940 hour 4 A.M. minute ____ M.
21. I hereby certify that I attended the deceased from Aug 15, 1940, to Oct 13, 1940, that I last saw him alive on Oct 13, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to Injury	
Due to	
Other conditions (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)
(b) Date of occurrence
(c) Where did injury occur? St. Charles (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Mo. Highway (Specify type of place)
While at work? No (e) Means of injury Road
23. Signature L. R. Hardin (M. D. or other)
Address St. Charles Mo. Date signed 10-17-1940

(Licensed Embalmer's Statement on Reverse Side)

144B
99

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 John E. Dallmeyer

Licensed Embalmer No. 2951

P. O. Address St Charles Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
—2-21-40
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36223

Registration District No. 757 Primary Registration District No. 2036 Registrar's No.

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town St Charles
(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 years, months or days)
In this community

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 Joseph Lackland
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 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 56 Months 10 Days 6 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13 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 Coronary Embolism

Due to Injury probably 5 months ago resulting in a bone in a bone clot

Due to Injury due to Injury

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature T. H. Hardin (M. D. or other)
Address St Charles, Mo. Date signed 12-19-40

SUPPLEMENTARY