

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 39023

Registration District No. 460

Registration District No. 4274

Registrar's No. 57

324  
5  
1

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

DEC 11 1940

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Higginsville  
(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  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette  
(c) City or town Higginsville  
(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 Margaret Luck (Maggie)

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 16 1865  
(Month) (Day) (Year)

8. AGE: Years 84 Months 2 Days 16 If less than one day 1865 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St Paul Minn  
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

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

12. Name Louis A Luck

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

14. Maiden name Mary Weber

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

16. (a) Informant Mammie Luck

(b) Address Higginsville Mo

17. (a) Buried (b) Date thereof 11-4-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville Mo

18. (a) Signature of funeral director John Meinershagen

(b) Address Higginsville Mo

19. (a) 1100-3080 (b) Ernest Webb  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2  
year 1940 hour 11 minute 45 P.M.  
21. I hereby certify that I attended the deceased from Oct 24 1940  
\_\_\_\_\_, 19\_\_\_\_, to Nov 2, 19\_\_\_\_;  
that I last saw her alive on Nov 1, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death uraemia ✓

Due to Epilepsy + Myocarditis  
Due to \_\_\_\_\_  
Other conditions.  
(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?  
412  
(Specify type of place) (e) Means of injury \_\_\_\_\_  
Signature W. Bruce Klein M.D.  
Address Higginsville MO Date signed Nov 4

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

9318-1

RECEIVED

District Health Officer No. 8, 8

District File Number \_\_\_\_\_

Date Filed 12-5-40

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 Roy F. Wiegman

Licensed Embalmer No. 2883

P. O. Address Hugginsville Md

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. 39023

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 460

Primary Registration District No. 4274

Registrar's No.

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

1. PLACE OF DEATH

(a) County Lafayette  
(b) City or town Hannibal  
(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 Margaret Luck (Maggie)

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
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 84 Months 2 Days 16 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) May 5 1941 (b) T. J. Webb (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month 7 day 20 year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above. Immediate cause of death.

Due to.

Due to.

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?

While at work (Specify type of place) (e) Means of injury

23. Signature W. A. Brocklin (M. D. or other)

Address Hannibal Mo Date signed

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 460

Primary Registration District No. 4274

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

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

ROWE

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Wigginsville  
(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

Margaret Luess

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

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

4. Sex F

5. Color or race W

6. (a) Single, widow, divorced, married 8

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

Months

Days

If less than one day

84

2

16

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) \_\_\_\_\_

(b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(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.

DEATH CERTIFICATION

20. DATE OF DEATH: Month 11 day 2  
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 uremia

Duration

Due to Epilepsy, Myo Carditis

Due to Geo. Lhu. Nephritis

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? \_\_\_\_\_ (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)  
(c) Means of injury \_\_\_\_\_

23. Signature W. B. Brackley (M. D. or other) MD

Address Wigginsville Mo Date signed \_\_\_\_\_

SUPPLEMENTARY