

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

39518

Do not use this space.

REC'D DEPT. OF HEALTH
NOV 18 1940

1. PLACE OF DEATH
 (a) County Platte Registration District No. 694
 (b) Township Beverly MO Primary Registration District No. 6921
 (c) ~~City~~ See above (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Julian Logston
 (a) Residence, No. St. Leavenworth Kansas St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May, 16, 1906

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>34</u>	<u>6</u>	<u>X</u>	

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

9. Industry or business in which work was done, as saw mill, bank, etc. U. S. Army

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 4

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

FATHER
 13. NAME Un Known
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Un Known

MOTHER
 15. MAIDEN NAME UN KNOWN
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT William S. Moore 1st Lt., CH
 (ADDRESS) Ft, Leavenworth Kansas

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 16, 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at 9:15 P.M.

The principal cause of death and related causes of importance were as follows:
Automobile accident on highway # 92 near Beverly. The spine neck was broken and a fractured right knee and ankle was thrown through windshield onto the pavement. was riding in a automobile which struck head on with a oncoming car.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide Accident Date of injury Nov. 16, 1940
 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) Leland H. Francis M. D.
 (Address) Parkville Mo NOV 18 1940

18. ~~HUMAN REMAINS OR~~ REMOVAL
 PLACE Blackburn MO DATE 11-19 40

19. FUNERAL DIRECTOR (NAME) John F. Thompson
 (ADDRESS) LEAVENWORTH KANSAS

20. FILED Nov 17 1940 Mr. A. E. Farnham Local Registrar

WHITE 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 X14028

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.

Removed from accident to Station
Hospt. Ft. Leavenworth Kansas, by
Government Ambulance.

STATE BOARD OF HEALTH
Division of Vital Statistics, State of Kansas

Registrar's Office

DEC 11 1940

1. PLACE OF DEATH:
(a) County Wichita
(b) City or township Wichita, Mo.
(If outside city or town limits, write RURAL.)
(c) Name of hospital or institution: None
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution: 1 mo
(Specify whether
In this community 9-9/12 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Leavenworth
(c) City or town West Leavenworth
(If outside city or town limits, write RURAL)
(d) Street No. Service Co. District, Green (DCE)
(If rural give location)
(e) If foreign born, how long in U. S. A.? 000 years.

3 (a) FULL NAME JULIAN E. ROBERTS
3 (b) If veteran, name war None 3 (c) Social Security No. None

20. Date of death: Month November day 16th
year 1940 hour 9 minute 15 PM
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.

4. Sex Male 5. Color or race White 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 May 26 1905
(Month) (Day) (Year)

Immediate cause of death Arteriosclerosis and atherosclerosis of the heart and coronary arteries, due to coronary artery disease, which caused a myocardial infarction of the left ventricle of the heart.
Due to _____
Due to _____
Other conditions coronary artery disease
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
34 6 0 _____ min.
9. Birthplace Wichita, Mo. (City, town or county) (State or foreign country)
10. Usual occupation Soldier (Army)
11. Industry or business _____
12. Name Robertson
13. Birthplace Wichita (City, town or county) (State or foreign country)
14. Maiden name Wichita
15. Birthplace Wichita (City, town or county) (State or foreign country)

Major findings: 0
Of operations _____
Of autopsy Autopsy performed and diagnostic material.

16 (a) Informant's own signature Wichita, Mo. 10/20/40
(b) Address West Leavenworth, Mo.
17 (a) _____ (b) Date thereof _____
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18 (a) Signature of funeral director LEAVENWORTH, KANSAS
(b) Address _____
19 (a) _____ (b) Mrs. A. E. Faulkner
(Date received local registrar) Nov 17 (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accidental
(b) Date of occurrence November 16, 1940
(c) Where did injury occur? Wichita, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home or farm, in industrial place, in public place? U.S. Army
While at work? _____ (e) Means of injury Accidental
23. Signature of physician Prof. Edward H. Dr. note (M. D. or other)
Address Wichita, Mo. Date signed 9-16-40

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

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. 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.

18-3489-9 3-40-80M

A TRUE COPY.

1940
S-39518

Station Hospital,
Fort Leavenworth, Kansas.
November 18, 1940.

William S. Moore
WILLIAM S. MOORE,
1st Lt. Med. Res. C.,
Adjutant.

Note: Other data left blank by the Coroner of Pasterville, Missouri,
filled in on this copy to make record complete as far as possible. Other
data same as original copy of Death Report furnished by the Coroner.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 700

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 694

Primary Registration District No. 5921

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Platte
(b) City or town Boonville
(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 Julian Logston
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 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 34 Months 8 Days 0
If less than one year _____ 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 (Month) (Day) (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 18 1940 (b) Mrs. G. E. Faneland
(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 700 day 16
year 1940 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to Kidney infection
meas

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? _____

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

23. Signature Leland H. Franey (M.D. or other) _____

Address Parkville, Mo. Date signed _____

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

SUPPLEMENTAL

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