S. No. 2
4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42008

Registration District No. 104 | Primary Registration District No. 3008 | Registrar's No. 328

14
2
2

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

1. PLACE OF DEATH:
(a) County: Callaway
(b) City or town: Fulton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp #1 Fulton (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 mo 23 days (Specify whether years, months or days) In this community: 3

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Pike
(c) City or town: Louisiana Mo. (If outside city or town limits, write "RURAL")
(d) Street No.: 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Harvey Lain
3. (b) If veteran, name war: 0
3. (c) Social Security No.: DK
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: DK
6. (c) Age of husband or wife if alive: DK years
7. Birth date of deceased: DK (Month) (Day) (Year)
8. AGE: Years: 79 (aprox) Months: Days: If less than one day: hr. min.
9. Birthplace: Pike Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business: 9
MOTHER FATHER
12. Name: DK
13. Birthplace: DK (City, town, or county) DK (State or foreign country)
MOTHER
14. Maiden name: DK
15. Birthplace: DK (City, town, or county) (State or foreign country)
16. (a) Informant: State Hosp. #1 Records
(b) Address: Fulton Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12 9 40 (Month) (Day) (Year)
(c) Place: burial or cremation: Columbia Mo
18. (a) Signature of funeral director: G. B. Roberts
(b) Address: Columbia Mo
19. (a) Dec. 9. 1940. (Date received local registrar) (b) R. N. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 6th year: 1940 hour: 5 minute: 45 P. M.
21. I hereby certify that I attended the deceased from Oct 14, 1940, to Dec 6th, 1940 that I last saw h. alive on Dec 6th, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia — Duration: 4 days
Due to:
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: No
(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: Geo. F. Wood (M. D. or other) Igno
Address: State Hosp #1 Fulton Mo Date signed: 12/7/40

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.