

JAN 25 1941 774
Registration District No. 774

Primary Registration District No. 601813

Registrar's No. 1004

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Esther
(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 five days years, months or days) 3

3. (a) PRINT FULL NAME Odas Harvey Loughary
3. (b) If veteran, name war # _____ 3. (c) Social Security No. # _____

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 October 28, 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 2 1 hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name Odas Loughary
13. Birthplace Flat River Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Wallen
15. Birthplace Belleview Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Odas Loughary
(b) Address Arcadia Mo.

17. (a) burial (b) Date thereof 12/30/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Belleview Mo.

18. (a) Signature of funeral director Norman White & sons
(b) Address Flat River Mo.

19. (a) 12/30/40 (b) C. B. Starnes M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Iron
(c) City or town Arcadia (Rural)
(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 Dec. day 29
year 1940 hour 8 minute A. M.

21. I hereby certify that I attended the deceased from Dec 26, 1940 to Dec 29, 1940
that I last saw him alive on Dec 28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 6 day

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:
(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? Yes

6:00 While at work? _____ (Specify type of place) _____ (e) Means of injury 2

23. Signature J. W. Snodan (M.D. or other) Dr.
Address Flat River Mo. Date signed 12/29/40

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

1072

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43748

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 729

Primary Registration District No. 6018 B

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town St. Francois
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Edas Harvey Loughery

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 _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 1 _____ hr. _____ min.

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

10. Usual occupation _____

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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
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 Broncho pneumonia

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: None
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 J. W. Zuppano

Address 1st St. R. 2nd Date signed 7/9/40

SUPPLEMENTAL COPY

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

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

MOTHER FATHER

