

FILED FEB 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2119

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
South side Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME David Bennett Lasley

8. (b) If veteran, name war _____ 8. (c) Social Security No. 500-07-5012

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Minerva Lasley 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Feb 6 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>11</u>	<u>17</u>	hr. min.

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

10. Usual occupation Police Man

11. Industry or business Carpenter

MOTHER FATHER { 12. Name Baldwin Lasley

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

14. Maiden name Aronista Leslie

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

16. (a) Informant Mrs David Lasley

(b) Address Carrollton Mo.

17. (a) Burial (b) Date thereof Jan 26 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill

18. (a) Signature of funeral director Willis Marshall

(b) Address Carrollton Mo.

19. (a) 1-24-41 (b) W. H. Haskins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll
(c) City or town Carrollton
(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 Jan day 23
year 1941 hour 3 minute 10 P.M.

21. I hereby certify that I attended the deceased from Jan 10
4 + 6 pm, 1941, to 23, 1941;
that I last saw alive on _____, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction
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) OH

(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? 130
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature R. M. Brown
Address Carrollton Mo. Date signed 1-24-41

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

17-39
X21492

122 B

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 17-8-6

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 myself

....., Registered Apprentice No.
working under my personal supervision.

Signed R. M. Marshall

Licensed Embalmer No. 2575

P. O. Address Carrollton Mo.

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.

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME David Bennett Hasley

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 32 Months 11 Days 17 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) (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

20. DATE OF DEATH Month Jan day 23 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 Intestinal Obstruction

Due to full view atop of jaw -

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 10/6/21 Of autopsy 7/21

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 Mark Benson (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

Duration 11
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

