

**MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH**

State File No. **10420**

Registration District No. **201**

Primary Registration District No. **5280**

Registrar's No. **35**

1. PLACE OF DEATH:
 (a) County **Loblay**
 (b) City or town **Liberty, Mo. Chandler**
 (c) Name of hospital or institution **County Home**
 (d) Length of stay: In hospital or institution **12 days**
 In this community **2 years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Loblay**
 (c) City or town **Liberty, Mo. R.H. 2**
 (d) Street No. **0**
 (e) If foreign born, how long in U. S. A. **25** years.

3. (a) PRINT FULL NAME **Hilas Lutz**
 (b) If veteran, name war **no** (c) Social Security No. **none**
 4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife **none** 6. (c) Age of husband or wife if alive **—** years
 7. Birth date of deceased **— 1876**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Mar**, day **25**, year **1941** hour **9** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Mar 11, 1941** to **Mar 25, 1941**; that I last saw him alive on **Mar 25, 1941**; and that death occurred on the date and hour stated above.
 Immediate cause of death **Hemorrhage from Carcinoma of Liver + Gall Bladder**

8. AGE: Years **65** Months **—** Days **—** If less than one day hr. min.

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

9. Birthplace **3 Switzerland**
 10. Usual occupation **Laborer**

Major findings: _____
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business **Unknown**
 12. Name **Unknown**
 13. Birthplace **Unknown**
 14. Maiden name **Unknown**
 15. Birthplace **Unknown**

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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? **At home**

16. (a) Informant's own signature **Joak Thast**
 (b) Address **Chandler Mo**
 17. (a) **Burial** (b) Date thereof **Mar 26-1941**
 (c) Place: burial or cremation **County Home Chandler, Mo**
 18. (a) Signature of funeral director **Church - Weber Co**
 (b) Address **Liberty, Mo**
 19. (a) **Mar 26-41** (b) **Helen Carley**

23. Signature **Dwight Malby** (M. D. or other) **M.D.**
 Address **Liberty, Mo** Date signed **4-3-41**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp.

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RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4-10-41

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 Edgar Archer

Licensed Embalmer No. 2211

P. O. Address Liberty, Me

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. 201

Primary Registration District No. 2280

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Liberty, Mo.
(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 Hilias Lutz

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

4. Sex M 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 _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ 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 _____

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) _____ (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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 25
year _____ hour _____ minute _____ M.

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

Immediate cause of death Hemorrhage from carcinoma of P. River + S. Gall Bladder
Due to _____
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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

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

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

S-10420 1941