No. 2
11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24663

District No. 96 97

Primary Registration District No. ~~5142~~ 5143

Registrar's No. 17

3
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0

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

1. PLACE OF DEATH:

(a) County Caldwell Kidder Twp

(b) City or town Rural ~~Hamilton~~ Twp
(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 3 years, months or days)

2. USUAL RESIDENCE OF DECEASED: 048

(a) State Missouri (b) County Jackson 13 8

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 72-46 Olive St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Mrs. Mary Lease Larimore

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE 1

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED 1

6. (b) Name of husband or wife James Larimore

6. (c) Age of husband or wife if alive 30 years

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

8. AGE: Years | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant

(b) Address

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 1 1941 (Month) (Day) (Year)

(c) Place: ~~burial or cremation~~ Kansas City Mo

18. (a) Signature of funeral director G. R. Hamilton

(b) Address Hamilton Mo

19. (a) July 1 1941 (Date received local registrar) (b) ~~Marie Brown~~ H. F. Powell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw her alive on dead July 1, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Puncture above eye Crushed Chest many Contusions and lacerations

Due to Body Auto. Colisions

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations no operation

Of autopsy above findings.

Duration

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 July 1 — 013

(c) Where did injury occur? U S Hiway 36 Caldwell Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? On public highway (Specify type of place)

While ~~at work~~? In car (e) Means of injury Collision

23. Signature E. A. Thompson (M. D. or other) Coroner 3

Address Breckenridge Mo Date signed 7-1-41

(Licensed Embalmer's Statement on Reverse Side)

APR 28 1947

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
1—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24663

Registration District No. 97 Primary Registration District No. 514B Registrar's No. 17

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Rural
(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)

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

3. (a) PRINT FULL NAME Mary L. Laremore

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 unable to ascertain
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day
could not get information hr. min.

9. Birthplace unable to ascertain
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business

MOTHER FATHER
12. Name unable to ascertain
13. Birthplace
(City, town, or county) (State or foreign country)

MOTHER FATHER
14. Maiden name unable to ascertain
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant Dr Thompson (coroner)

(b) Address Breckenridge Mo

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) Sept 24 1941 (Date received local registrar) (b) Merle Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 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.

	Duration
Immediate cause of death	
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)

(b) 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 (M. D. or other)

Address Date signed

S No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24663

Registration District No. 97 Primary Registration District No. 5743 Registrar's No. 17

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

Breckenridge Mo

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Mary L. Larimore
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
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 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
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)

SUPPLEMENTARY

170 C

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 1 year 1941 hour P. M. 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 Puncture above left crushed chest many fractures + lacerations — Duration
Due to 1 body, auto collision of 2 cars, head on, on U.S. highway
Due to no 36, Instant death
Other conditions Our car going East met car going West head on collided
(Include pregnancy within 3 months of death)

Major findings:
Of operations no operation
Of autopsy above findings

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) accident
(b) Date of occurrence July 1
(c) Where did injury occur? U.S. Highway 36 Caldwell Mo (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? on public highway U.S. 36 (Specify type of place)
While at work? No (b) Means of injury Collision
23. Signature E. A. Thompson (M. D. or other)
Address Breckenridge Mo Date signed 9-13-41