

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

24764  
Do not use this space.

FILLED AUG 13 1941

1. PLACE OF DEATH  
(a) County Cape Girardeau Registration District No. 130  
(b) Township Welch Primary Registration District No. 5175  
(c) City Delta, Mo. (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. da. (f) How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. mos. ds.  
2. PRINT FULL NAME Norothy Ann LaGrand  
(a) Residence, No. \_\_\_\_\_ St.  Caruthersville, Mo.  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) infant  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF infant  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8 11

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Caruthersville, Mo.

FATHER 13. NAME John LaGrand

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Delta, Mo.

MOTHER 15. MAIDEN NAME Violet Grant

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) John LaGrand

18. BURIAL, CREMATION, OR REMOVAL PLACE Allienville DATE July 6 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Seaburg Farm Cape Girardeau

20. FILED July 5 1941 Mrs. M. Stiebler Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 5 1941  
2. I HEREBY CERTIFY, That I attended deceased from July 4, 1941, to July 5, 1941.  
I last saw h. apt. live on July 4, 1941. Death is said to have occurred on the date stated above, at 2:30 m.  
The principal cause of death and related causes of importance were as follows:

Duo Colitis  
Date of onset June 24 41  
Other contributory causes of importance: none

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation? no  
If so, specify none

(Signed) M. W. Stiebler M. D.  
Allienville, Mo.  
(Address) \_\_\_\_\_

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**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, above space should be left blank.**