

Registration District No. 89

Primary Registration District No. 3007

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Poplar Bluff Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 1 Week
(Specify whether)

In this community Years
years, months or days

3. (a) PRINT FULL NAME AUB H. LAUNIUS

3. (b) If veteran, name war %--

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Estelle Launius

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

7. Birth date of deceased Sept. 2, 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>3</u>	<u>1</u>	hr. <u>min.</u>

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Jim Launius

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

14. Maiden name Anna Mays

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

16. (a) Informant Mrs. Aud Launius

(b) Address Bloomfield, Mo. Rural

17. (a) Burial (b) Date thereof 2-4-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walkers cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) 2-7-42 (b) Belle Kinnel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 103

(a) State Missouri (b) County Stoddard 20

(c) City or town Bloomfield, Mo. Rural 0
(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 Feb day 3
year 1942 hour 9:30 minute A. M.

21. I hereby certify that I attended the deceased from Jan 28, 1942, to Feb 3, 1942;
that I last saw him alive on Feb 3, 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 2 weeks

Due to Nephritis ?

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy None

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? _____

While at work? _____
(Specify type of place) (e) Means of injury 0

23. Signature J. P. Brackman (M.D. or other) _____
Address Poplar Bluff, Mo. Date signed 2-3-42

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

RECEIVED

District Health Office No. 2,

District File Number 242-210

Date Filed 2-11-42

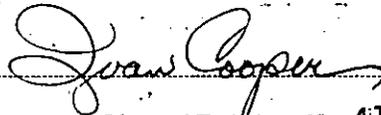
STATEMENT BY LICENSED EMBALMER

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. 4119

P. O. Address Bloomfield, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 89

Primary Registration District No. 3007

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Caplan Bluff
(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 Rud H. Laundius

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 2 Year 1942 hour _____ minute _____ M.

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

Immediate cause of death _____

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: Sept 2 1893
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>48</u>	<u>3</u>	<u>14</u>	<u>min.</u>

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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)

SUPPLEMENTARY

Due to history of visit to a St. Louis Hospital where they told him he had renal tuberculosis

Major findings: tuberculosis

Of operations _____

Of autopsy 20

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

