

Registration District No. 449

Primary Registration District No. 5609

Registrar's No. _____

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEBANON TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R. 2, LEBANON 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community ALWAYS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County LACLEDE
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. R. 2, LEBANON
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

JOHN W STREET

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 WIDOWER

6. (b) Name of husband or wife MISS MINNIE ROBINSON 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased APR 13-1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>8</u>	<u>26</u>	hr. min.

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

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name HIRAM H STREET

13. Birthplace MISS 1
(City, town, or county) (State or foreign country)

14. Maiden name FRANCIS WHITNEY

15. Birthplace MISS 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Jasper Truhove

(b) Address LEBANON MO

17. (a) BURIAL (b) Date thereof 1-13-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DODSON CEM,

18. (a) Signature of funeral director PALABRIS

(b) Address LEBANON MO

19. (a) Jan 10-42 (b) Grace Roper
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 9
year 1942 hour 11 minute A M.

21. I hereby certify that I attended the deceased from Oct 4, 1941 to Jan 9, 1942
that I last saw him alive on Jan 9, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Uremic Coma 2 days

Due to Apoplexy 3 days

Due to Hypertension Unknown

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) no

(b) Date of occurrence none

(c) Where did injury occur? none
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none

While at work? no (Specify type of place) (e) Means of injury no

23. Signature James L. Hope (M. D. or other) 1
Address Lebanon, Mo. Date signed 1/10/42

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

RECEIVED

District Health Officer No.

District File Number 1-42-39

Date Filed 1-24-42

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

Allyn Dethorage, Registered Apprentice No. 294
working under my personal supervision.

Signed [Signature]

Licensed Embalmer No. 1161

P. O. Address LEBANON MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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

State File No. 2667
Registrar's No.

Registration District No. 449

Primary Registration District No. 5609

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

1. PLACE OF DEATH: Laddebo
 (a) County Rural
 (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

3. (a) PRINT FULL NAME John W Street
 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 _____

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

7. Birth date of deceased: Apr 13
 (Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days _____ If less than one day _____ 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 _____
 (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)

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 Jan day _____
 year 1942 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____
 to _____, 19____;
 that I first saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Chronic Nephritis 3 yrs
Hypertension 6 yrs
 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)
 (c) Means of injury _____
 23. Signature James L. Hope (M. D. or other) _____
 Address Rebanon, Mo. Date signed 3/4/42

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

