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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 6 1942

Registration District No. 8842

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19147

Primary Registration District No. 6049

Registrar's No. 13

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

1. PLACE OF DEATH:
(a) County Schuyler
(b) City or town Glenwood Twp (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: NO
(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 78 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Schuyler
(c) City or town Glenwood – Rural
(If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME James Nelson Lucas
3. (b) If veteran, name war .....
3. (c) Social Security No. –
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lucetta Belle
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased March (Month) 29 (Day) 1864 (Year)
8. AGE: Years 78 Months 1 Days 18 If less than one day ..... hr. ..... min.
9. Birthplace Schuyler Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Farmer
11. Industry or business .....
FATHER
12. Name Samuel Lucas
13. Birthplace Kentucky (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mariah Ray
15. Birthplace Schuyler Co Mo (City, town, or county) (State or foreign country)
16. (a) Informant Floyd Lucas
(b) Address Glenwood Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Glenwood Cemetery
18. (a) Signature of funeral director Moreheads
(b) Address Lancaster Mo
19. (a) May 18, 1942 (Date received local registrar) (b) A. A. Justice (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18 year 1942 hour 7 minute 9 A. M.
21. I hereby certify that I attended the deceased from May 13 1942 to May 18 1942 that I last saw him alive on May 16 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Infirmities of age

Due to an accident resulting in a broken hip, from which he never fully recovered

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

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

23. Signature H. L. Johnson (M. D. or other)
Address Glenwood Mo. Date signed 5-18-42

1278 (Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:
(a) County .....
(b) City or town ..... (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) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME .....
3. (b) If veteran, name war ..... 3. (c) Social Security No. .....
4. Sex ..... 5. Color or race ..... 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 ..... (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 .....
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) Date of interment ..... (Burial, cremation, or removal) ..... (Month) (Day) (Year)
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) ..... (Date received local registrar) ..... (b) ..... (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.
Immediate cause of death ..... Duration .....
Due to .....
Due to .....
Other conditions .....
(Other conditions may 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? ..... (Specify type of place)
(e) Means of injury .....
23. Signature ..... (M. D. or other)
Address ..... Date signed .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 10
District File Number 6-42-1796
Date Filed JUN 2 - 1942

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 Truss Mine Morehead, Registered Apprentice No. ..... working under my personal supervision.

Signed Morehead

Licensed Embalmer No. 3731-3680

P. O. Address Lancaster Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

(Licensed Embalmer's Statement on Reverse Side)

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

U.S. No. 2B
0M—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. 19147

Registration District No. 802 Primary Registration District No. 6049 Registrar's No.

1. PLACE OF DEATH:
(a) County: Schuyler.
(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: James N. Lucas
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: M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Mar. (Month) 29 (Day) 1864 (Year)
8. AGE: Years 78 Months 1 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day
year 1942 hour 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: Broken Hip. Duration 1 hr.
Due to: He was riding on a sled drawn along the
Due to: public road drawn by 2 or 3 years ago
Other conditions: leg had broken in 2 pieces
(Include pregnancy within 3 months of death)
Major findings: by timber of Bogel K
Of operations: Dang sick through the sled through fence of
Of autopsy: fracture his hip

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): Just an accident
(b) Date of occurrence
(c) Where did injury occur? Schuyler Co Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? No (Specify) Nature of injury: He gradually failed in health

23. Signature: N. F. Johnson (M. D. or other)
Address: Glenwood Mo. Date signed 7-15-42

SUPPLEMENTARY