

JUL 20 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21701

State File No.

Registration District No. 518

Primary Registration District No. 5694

Registrar's No. 37

1. PLACE OF DEATH:

(a) County McDonald  
 (b) City or town Rural, Seneca Mo. R. 1  
 (c) Name of hospital or institution: The Miller Prof  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community 50 yrs  
 years, months or days (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald  
 (c) City or town Seneca Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. RFD # 1  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME ETHEL MAY LAGERS

3. (b) If veteran, name war..... 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife Price Lagers 6. (c) Age of husband or wife if alive..... years  
 7. Birth date of deceased 7 - 24 - 1880  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 11 2 hr. min.

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

10. Usual occupation House wife

11. Industry or business.....

MOTHER FATHER  
 12. Name Marshall Spragg  
 13. Birthplace Unknown  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Wendy Spragg  
 15. Birthplace Kansas  
 (City, town, or county) (State or foreign country)

16. (a) Informant Eva M. Lagers

(b) Address Seneca Mo. R. 1

17. (a) Burial (b) Date thereof 7-28-42  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baptist Cemetery

18. (a) Signature of funeral director Bill Buzzard

(b) Address Seneca Mo.

19. (a) June 28 1942 (b) A. W. Muschel  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26  
 year 1942 hour 8 PM 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 No Doctor  
Natural Causes  
Bed fast four months

Due to Didn't believe in

Due to doctors or in taking

medicine account of

Other conditions Religious belief  
 (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)

(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 8

23. Signature Bill Buzzard Undertaker  
 Address Seneca Mo. Date signed.....

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

RECEIVED

District Health Officer No. 6,

District File Number 742-1027

Date Filed JUL 17 1942

RECEIVED  
14-15-3-100  
EX-100

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: *J. W. Buzzard*  
Licensed Embalmer No. 4215  
P. O. Address Seneca Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. ....

Primary Registration District No. 3694

Registrar's No. 37

1. PLACE OF DEATH:

(a) County M' Donald  
(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 3.0 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County M' Donald  
(c) City or town Rural  
(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 Ethel M. Lagers

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 W

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

7. Birth date of deceased July-24- (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>11</u>	<u>11</u>	<u>11</u> min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to Natural Causes 178

Due to no physician

Other conditions W.M.O. (Include pregnancy within 3 months of death)

Major findings: Of operations 2000

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) (e) Means of injury \_\_\_\_\_

23. Signature W.W. Mitchell (M.D. or other)

Address Andover Mo Date signed 7-24-42

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-21701