DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25419

AUG 28 1942

Registration District No. 141

Primary Registration District No. 6040

Registrar's No.

1. PLACE OF DEATH:

(a) County: Saline

(b) City or town: R.F.D. Miami, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: no In this community: born there (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Saline

(c) City or town: R.F.D. Miami, Mo. (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.? 0 years.

3. (a) PRINT FULL NAME: Lula May Mendenhall

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: female

5. Color or race: white

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

6. (b) Name of husband or wife: D.C. Mendenhall

6. (c) Age of husband or wife if alive: 51 years

7. Birth date of deceased: May (Month) 29 (Day) 1890 (Year)

8. AGE: Years 52 Months 1 Days 21 If less than one day hr. min.

9. Birthplace: Saline County (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: housewife

11. Industry or business:

FATHER 12. Name: W. P. Hardin

FATHER 13. Birthplace: Saline Co. (City, town, or county) Mo. (State or foreign country)

MOTHER 14. Maiden name: Addie Martin

MOTHER 15. Birthplace: Ky. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: D. C. Mendenhall,

(b) Address: R.F.D. Miami, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 7-21-'42 (Month) (Day) (Year)

(c) Place: burial or cremation: Slater, Mo.

18. (a) Signature of funeral director: Hill Brothers

(b) Address: Slater, Mo.

19. (a) 7/24/42 (Date received by registrar) (b) Mrs. John Geiger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20th year 1942 hour 3 minute a M.

21. I hereby certify that I attended the deceased from April 5 42, 19..., to July 18 42, 19..., that I last saw her alive on July 18 42, 19..., and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia - Bilateral — Duration: 3 days

Due to: Infection

Due to: Atrophic Lateral Sclerosis

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

Major findings: Of operations: None

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): no

(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: W. E. Lechwood (M. D. or other) MD

Address: Slater Mo Date signed 7/20 42

(Licensed Embalmer's Statement on Reverse Side)

1211

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1 X19511

RECEIVED
District Health Officer No. 8,
Local File Number .....
Date Filed 7-27-42

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 R. C. Hill

Licensed Embalmer No. 3090

P. O. Address Slater, 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, above space should be left blank.

S. No. 2B
M—8-21-41
1 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. 25419

Registration District No. 797 Primary Registration District No. 6040 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Saline
(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 Lula May Mendenhall
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 m
6. (b) Name of husband or wife D.C
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 29 (Day) 1889 (Year)
8. AGE: Years 52 Months 1 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (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 July Day 29 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.

	Duration
Immediate cause of death Pneumonic Bacterial Superimposed or Based	3 days
Due to Infection	
Due to Amyotrophic lateral Sclerosis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M.D. or other)
Address Sedalia Mo. Date signed 9/2/42

109.1