V. S. No. 2
DM—9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 29 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27520

Registration District No. 448 Primary Registration District No. 4267 Registrar's No.

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

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town ~~WAS~~ LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WALLACE O HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS (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 LEBANON
(If outside city or town limits, write "RURAL")
(d) Street No. R 1
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME RUFUS CAROL HAGGARD

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M O
5. Color or race W
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife UNITA E COFFMAN
6. (c) Age of husband or wife if alive years
7. Birth date of deceased MAR (Month) 14 (Day) 1855 (Year)

8. AGE:

Years	Months	Days	If less than one day
87	4	4	hr. min

9. Birthplace WRIGHT CO (City, town, or county) ~~TEN~~ MO (State or foreign country)
10. Usual occupation RETIRED FARMER
11. Industry or business
FATHER
12. Name C. F. HAGGARD
13. Birthplace (City, town, or county) U.S. (State or foreign country)
MOTHER
14. Maiden name MARY LORANCE
15. Birthplace (City, town, or county) MO (State or foreign country)
16. (a) Informant W. G. Dourne
(b) Address Lebanon Mo. R.1
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-19-42 (Month) (Day) (Year)
(c) Place: burial or cremation WHITE OAK POND
18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO
19. (a) July 16 42 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 18 year 1942 hour 6 minute A M.
21. I hereby certify that I attended the deceased from July 15, 1942, to July 18, 1942 that I last saw him alive on July 17, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Oedema Lungs	
Due to High Blood Pressure	
Due to Fractured Hip	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

186a
18

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)~~ fairly
(b) Date of occurrence July 15 42
(c) Where did injury occur? at house (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 Fall
23. Signature J. L. Benage (M. D. or other)
Address Lebanon, Mo Date signed 7/8-42

1090 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Lake Co. Health Dept.
~~District Health Officer No.~~
~~District~~ File Number 8-42-121
Date Filed 8-27-42

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

Signed D A Bohner

Licensed Embalmer No. 1161

P. O. Address Lebanon Ind.

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.