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7. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1942

Registration District No. 287

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31115

Primary Registration District No. 5-9-7-5979

Registrar's No. 7

1. PLACE OF DEATH:

(a) County: Cook

(b) City or town: Willard, Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural 1 R 1 (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 DEATH:

(a) State: Missouri (b) County: Cook

(c) City or town: Willard Mo R 1 (If outside city or town limits, write "RURAL")

(d) Street No.: Rural (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: William A. Lemmon

3. (b) If veteran, name war: None

3. (c) Social Security No.: X

4. Sex: Male 0

5. Color or race: White

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

6. (b) Name of husband or wife: Minnie Fillingsworth

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

7. Birth date of deceased: December (Month) 4 (Day) 1859 (Year)

8. AGE: Years 82 Months 9 Days 22 If less than one day ..... hr. ..... min.

9. Birthplace: Walnut Grove (City, town, or county) – Missouri 0 (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: General Farming

FATHER
12. Name: Barrett Lemmon
13. Birthplace: Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Sarah A. McCannon
15. Birthplace: Georgia (City, town, or county) (State or foreign country)

16. (a) Informant: Lawrence C. Lemmon

(b) Address: Willard Mo R 1

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

(c) Place: burial or cremation: Highway Grove Cem

18. (a) Signature of funeral director: Geneva Boyer

(b) Address: Walnut Grove Mo.

19. (a) Oct-2-1942 (Date received local registrar) (b) Hillard Dickinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26 year 1942 hour 11 minute 50 P.M.

21. I hereby certify that I attended the deceased from Sept 15th 1942 to Sept 19th 1942 that I last saw him alive on Sept 19th 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Urinary Retention / Duration

Senility

Due to: Hypertension, Arteriosclerosis, Chronic Enlarged Prostate.

Due to .....

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) .....

(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: J. J. Barbieri M.D. (M. D. or other)

Address: Walnut Grove, Mo Date signed 9-30-42

1188 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 10-42-1118
Date Filed 10-9-42

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 Geneva Dunn

Licensed Embalmer No. 2664

P. O. Address Walnut Grove 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3 1115

Registration District No. 287 Primary Registration District No. 5978 Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Polk

(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: William A Lemmon

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: W

6. (b) Name of husband or wife

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

7. Birth date of deceased: Dec (Month) 4 (Day) 1858 (Year)

8. AGE: Years 82 Months 9 Days If less than one day hr. min.

9. Birthplace: (City, town, or county) Ohio (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 Sept Day 6 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: Uremic Poisoning, Chronic Nephritis

Due to: Senility

Due to: Hypertension, arteriosclerosis, Gallstones, Enlarged Prostate

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)

(b) 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY