

No. 4
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1854

State File No. _____

FILED JAN 18 1943 -

Registrar's No. 153-

Registration District No. _____

Primary Registration District No. 5795-

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Norborne R.R. & Pranks
(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) Imp

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll 17

(c) City or town Norborne - Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME STEPHEN, GILLRUTH, LINDSEY

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

4. Sex M. U 5. Color or race white 6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife Harriet 6. (c) Age of husband or wife if alive 90 years

7. Birth date of deceased June 10 1959
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

83 6 12 hr. min.

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER

12. Name Jonah Lindsey

13. Birthplace not known
(City, town, or county) (State or foreign country)

14. Maiden name Rachel Harmon

15. Birthplace not known
(City, town, or county) (State or foreign country)

16. (a) Informant Anita Sole

(b) Address 800 W. 17th St. N.E. Mo

17. (a) Burial (b) Date thereof 12 24 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Norborne Fairlawn

18. (a) Signature of funeral director John W. Kupfchile

(b) Address Hadding, Mo

19. (a) 12-22-42 (b) John Detch Desp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day Monday 21
year 1942 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from August 12 1942 to December 21, 1942
that I last saw h. im alive on December 21, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia ✓

Due to Cerebral hemorrhage 2 days

Due to Arterial hypertension some years

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? _____

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

23. Signature A. J. Gardner (M. D. or other) M.D.
Address Norborne Mo Date 12-22-42

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 1-15-12

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 me

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed

John W. Krupchick

Licensed Embalmer No.

2789

P. O. Address

Haidin 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1854

Registration District No. 55

Primary Registration District No. 5195

Registrar's No. 135

1. PLACE OF DEATH:

(a) County Carroll
(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 _____
years, months or days

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 Stephen G. Lindsey
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M 5. Color or race W 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 June 10
(Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ min.

9. Birthplace Ohio
(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) _____ (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 Dec 1
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I saw him/her _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death hypertensive
bronchial (a.s.)
cerebral hemorrhage

Due to arterial hypertension

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

Major findings: 107
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)
(a) Means of injury _____

23. Signature A. J. Gardner (M. D. or other)
Address Nordborne Mo. Date signed _____

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

SUPPLEMENTAL

