5-42
7-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

10135

State File No.

LED MAR 17 1943

Registration District No. 701

Primary Registration District No. 5393

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Douglas

(b) City or town Ava Benton Twp.
(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: 34

(a) State Missouri (b) County Douglas 0

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

(d) Street No. Route 2
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Evelyn Faye Lemmon

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 Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased June 27 (Month) 1942 (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	7	20	hr. min.

9. Birthplace Ava (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Doyle Lemmon
13. Birthplace Unknown (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Lininger
15. Birthplace Andrew County, Missouri 0 (City, town, or county) (State or foreign country)

16. (a) Informant Doyle Lemmon
(b) Address Route 2, Ava, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-43 (Month) (Day) (Year)
(c) Place: burial or cremation Home place

18. (a) Signature of funeral director Friends
(b) Address

19. (a) 3-4-43 (Date received local registrar) (b) Thelma S. Waters (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17
year 1943 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 27, 1942 to Feb 17, 1943;
that I last saw her alive on Feb. 17, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to

Due to

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)

(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 Dr. C. E. Harlan (M. D. or other) D.O.
Address Ava Mo. Date signed 3-2-43

1056

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 343 - 431
Date Filed MAR 16 1943

Parents of child did not body emblamed

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.

No. 2B
—8-21-41
I 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. 10132

Registration District No. 101 Primary Registration District No. 5393 Registrar's No. 19

1. PLACE OF DEATH:

(a) County: Douglas

(b) City or town: Ava (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: Evelyn Faye Lemmon

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: S

6. (b) Name of husband or wife

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

7. Birth date of deceased: June (Month) 27 (Day) 1943 (Year)

8. AGE: Years 0 Months 7 Days 29 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 17 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia	
Bronchial Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): 107	

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY