

21513

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

3. No. 2
5-4-41
17-39
X2944

Registration District No. 3

Primary Registration District No. 5359

Registrar's No. 23

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

1. PLACE OF DEATH:

(a) County Howell

(b) City or town (rural) Hutton Valley 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 Two months (Specify whether years, months or days)

In this community Two months

2. USUAL RESIDENCE OF DECEASED: 46

(a) State _____ (b) County 0

(c) City or town: 0
(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 0

3. (a) PRINT FULL NAME Joseph Loub

3. (b) If veteran, name war _____

3. (c) Social Security No. 395-01-7566

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Anna Tesky Loub

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased July 22 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>10</u>	<u>18</u>	_____ hr. _____ min.

9. Birthplace Racine Wisconsin
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Cabinet maker

MOTHER FATHER { 12. Name Jacob Loub

13. Birthplace Bohemia
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Bohemia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna Loub

(b) Address Pomona, Mo. R#1

17. (a) Burial (b) Date thereof 6-13-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mackey cemetery

18. (a) Signature of funeral director J.C. Burns

(b) Address Willow Springs, Mo.

19. (a) 6-13-43 (b) Manette Ferguson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1943 hour 11:55 minute _____ P. M.

21. I hereby certify that I attended the deceased from June 6, 1943 to June 10, 1943
that I last saw him alive on 6-10-1943
and that death occurred on the date and hour stated above.

Immediate cause of death (accidental) (188) injuries by animal (kicked by horse)

Due to Pneumothorax, Hemothorax Shock. 4 days

Duration

Due to _____

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations 188

Of autopsy 189

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) Accident 046

(b) Date of occurrence 6-6-43

(c) Where did injury occur? Pomona Howell Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home on Farm

While at work? yes (Specify type of place) Kicked by horse (e) Means of injury

23. Signature J. Callahan (M. D. or _____)

Address Willow Springs, Mo. Date signed 6-12-43

343

(Licensed Embalmer's Statement on Reverse Side)

MAY 6 1946

RECEIVED

District Health Officer No. 5,

District File Number 643380

Date Filed 6-15-43

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 J.C. Burns

Licensed Embalmer No. 3379

P. O. Address Hillow Springs, 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.

Registration District No. 143

Primary Registration District No. 8559

1. PLACE OF DEATH:

(a) County Haskell

(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 Mo (b) County Haskell

(c) City or town Pomona
(If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

3. (a) PRINT FULL NAME Joseph Louh

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1943 month _____ 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 _____

4. Sex M 5. Color or race W

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

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

7. Birth date of deceased: _____ (Month) July _____ (Day) 22 _____ (Year) 1908

Duration _____

Due to _____

Due to _____

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

8. AGE: Years 61 Months 10 Days _____ If less than one day _____ min.

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation _____

11. Industry or business _____

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)

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 _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER, FATHER

S-21513