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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Lafayette, Mo.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25394

State File No. _____

FILED AUG 11 1943

Registration District No. 171

Primary Registration District No. 4266

Registrar's No. 43

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

1. PLACE OF DEATH:

(a) County: Unknown Lafayette, Mo.
(b) City or town: Unknown Lafayette, Mo.
(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: Unknown (Specify whether)
years, months or days

3. (a) PRINT FULL NAME: Unknown White, Mrs.

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

4. Sex: male 5. Color or race: Unknown 6. (a) Single, widowed, married, divorced: Unknown

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

7. Birth date of deceased: unknown
(Month) (Day) (Year)

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

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

10. Usual occupation: _____

11. Industry or business: unknown

MOTHER FATHER { 12. Name: _____

18. Birthplace: unknown (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 (Burial, cremation, or removal) (b) Date thereof: 7-17-43 (Month) (Day) (Year)

(c) Place: burial or cremation: Wellington, Mo

18. (a) Signature of funeral director: W. G. Allen
(b) Address: Wellington Mo

19. (a) July 19 1943 (Date received local registrar) (b) Mrs W. F. Baker (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: _____
(c) City or town: _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Unknown Day: _____ Year: July 19 1943 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: Death from cancer unknown Duration _____

Due to: Body found in driveway in driveway

Due to: W. F. Baker

Other conditions: Arteriosclerosis (Include pregnancy within 5 months of death)

Major findings: Of operations: _____

Of autopsy: In 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: Unknown

(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: W. F. Baker (M.D. or other) _____
Address: Wellington Mo Date signed: 7-17-43

1157

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

8-10-43

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

W. P. Egan

Licensed Embalmer No.

4305

P. O. Address

Wellington, N.

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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHFILED AUG 11 1966
State File No. _____
Registrar's No. 43

Registration District No. 121

Primary Registration District No. 4266

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

1. PLACE OF DEATH

- (a) County Lafayette
 (b) City or town Wallington
 (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..... (Specify whether
years, months or days)3. (a) PRINT FULL NAME Unknown white man

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

5. Color or race.....

4. Sex..... 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 (Month) (Day) (Year)

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

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

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)

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)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....;

that I last saw him..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death.....

Duration

Due to.....

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?

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

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

Address..... Date signed.....

SUPPLEMENTARY

S-25394