No. 2
9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 10 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42837

Registration District No. 386 Primary Registration District No. 3039 Registrar's No. 14

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Marceline, Marceline 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 years, months or days)
In this community 20 years

2. USUAL RESIDENCE OF DECEASED: 58
(a) State Mo (b) County Linn
(c) City or town Marceline Rural
(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 Elsie Elvira Lloyd
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Rufus Lloyd
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Feb (Month) 6 (Day) 1893 (Year)

8. AGE: Years 50 Months 10 Days 22 If less than one day hr. min.

9. Birthplace Marceline (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Joseph Landreth
13. Birthplace Monarat (City, town, or county) Va. (State or foreign country)
MOTHER
14. Maiden name Metty Peery
15. Birthplace (City, town, or county) Mo (State or foreign country)
16. (a) Informant Rufus Lloyd
(b) Address Marceline Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec (Month) (Day) (Year)
(c) Place: burial or cremation Mt Olivet
18. (a) Signature of funeral director James McLaughlin
(b) Address Marceline Mo
19. (a) 1/10/43 (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month December day 27 year 1943 hour 1 minute 40 A.M.
21. I hereby certify that I attended the deceased from December 26, 1943, to December 27, 1943 that I last saw her alive on December 27, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Chronic myocarditis
Due to Chronic glomerular nephritis
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 131 f
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 G. H. Solomon (M. D. or other) D.O.
Address Marceline Mo Date signed 1-22-43

1500 (Licensed Embalmer's Statement on Reverse Side)

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 Blanche McLaughlin

Licensed Embalmer No. 1909

P. O. Address Marceline M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
P I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan.

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

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Marceline
(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 Elsie E. Lloyd

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 M

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Feb. (Month) 6 (Day) 1893 (Year)

8. AGE: Years 50 | Months 10 | Days 22 | 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 .....

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

MOTHER
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) 12-24-43 (Date received local registrar) (b) P. L. Patrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27
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	
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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

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

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

SUPPLEMENTARY

DEPARTMENT OF COMMERCE
Bureau of Vital Statistics

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH

(a) County

(b) City or town

(c) Street and number (If in hospital or institution, name instead of street)

(d) Length of stay: In hospital or institution

In this community

(Years) (months) (days)

(e) City or town

2. (a) FULL NAME

(b) Usual occupation

3. (a) Residence

(b) Street

(c) City or town

(d) County

(e) Is residence within city limits?

4. (a) Sex

(b) Color or race

(c) Married, widowed, divorced, or never married

5. (a) Date of birth (Month) (Day) (Year)

(b) Age (Years) (Months) (Days) If less than one day, hours or minutes

6. (a) Name of father

(b) Birthplace (State or country)

7. (a) Maiden name of mother

(b) Birthplace (State or country)

8. Was deceased ever in the Armed Forces of the United States?

9. Date of death (Month) (Day) (Year)

10. I hereby certify that I attended the deceased during the last illness; that I last saw the deceased alive on (Month) (Day) (Year); that death occurred on the date stated above, at the hour stated, from the causes stated below.

Signature

Date signed

Address

11. Place of death (Hospital or other institution, give name instead of street)

(a) County

(b) City or town

(c) Street and number

(d) Was death caused by accident, suicide, or homicide?

12. Date of injury (Month) (Day) (Year)

(a) Place of injury (Hospital or other institution, give name instead of street)

(b) City or town

(c) County

(d) Did injury occur while at work?

13. (a) Immediate cause

(b) Due to (or as a consequence of)

(c) Due to (or as a consequence of)

(d) Due to (or as a consequence of)

14. (a) Other significant conditions contributing to death but not related to the disease or condition causing death

(b) Was operation performed for any condition in item 14?

15. Was autopsy performed?

16. Were any findings of the autopsy available to complete the cause of death?

17. Did tobacco have an adverse effect on the deceased?

18. Did alcohol have an adverse effect on the deceased?

19. (a) Date of last menstrual period

(b) Was woman pregnant, recently pregnant, or within one year before death?

20. Was death due to injury by a motor vehicle?

21. (a) Was death due to injury at work?

(b) Was death due to injury in a public place?

22. Was death due to injury by a firearm?

23. (a) Was death due to injury by poisoning?

(b) Was death due to injury by drowning?

24. (a) Was death due to injury by fire or flame?

(b) Was death due to injury by electrocution?

25. (a) Was death due to injury by a sharp instrument?

(b) Was death due to injury by a blunt instrument?

26. (a) Was death due to injury by other means?

(b) Was death due to injury by other means?

27. (a) Was death due to injury by other means?

(b) Was death due to injury by other means?

28. (a) Was death due to injury by other means?

(b) Was death due to injury by other means?