

S. No. 2
M-2-43
-17-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

67490
State File No.

FILED JAN 11 1949

Registration District No. 12

Primary Registration District No. 6008

Registrar's No. 254

1. PLACE OF DEATH:

(a) County RANDOLPH
(b) City or town PRairie Township
(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 40 yrs
years, months or days

3. (a) PRINT FULL NAME Lucy Mc Cune

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

4. Sex 70 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Kelly Mc Cune 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Aug 4 1880
(Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Mo. 1
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

12. Name Daughter Ty

13. Birthplace Mo 1
(City, town, or county) (State or foreign country)

14. Maiden name Anderson

15. Birthplace Mo 1
(City, town, or county) (State or foreign country)

16. (a) Informant Joe Mc Cune

(b) Address Clark, Mo

17. (a) Burial (b) Date thereof Dec 14-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CHapel Grove

18. (a) Signature of funeral director E. E. Shupp

(b) Address Clarance, Mo

19. (a) 12-14-48 (b) Irma Haver
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Randolph
(c) City or town PRairie Township
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 12 day 12 year 1948 hour 1 minute 10 P. M.

21. I hereby certify that I attended the deceased from Dec 6 1948 to Dec 12 1948
that I last saw her alive on Dec 12 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Infarction
Prurichnoma

Due to Coronary sclerosis

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 R. Atwood (M. D. or other)

Address Clark Mo Date signed 12-14-48

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

MOTHER FATHER

43

RECEIVED

District Health Officer No. 10

District File Number 1-44-74

Date Filed JAN 10 1944

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..... *Louis C. Hoffer*

Licensed Embalmer No. 4261

P. O. Address..... *Clarence, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County *Randolph*

(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 years, months or days)

In this community _____

3. (a) PRINT FULL NAME *Lucy Mc Cune*

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 *on*

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

7. Birth date of deceased *Aug.* (Month) (Day) (Year)

8. AGE: Years *63* Months *4* Days *1* (If less than one day, min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name *A. Underwood*

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

14. Maiden name _____

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

16. (a) Informant *a fellow of the ...*

(b) Address _____

17. (a) _____ (b) Date thereof _____ (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)

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 *Dec* Day *12* Year *1943* 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 *Dyspnoeic Pneumonia*

Due to *Coronary Sclerosis*

Due to _____

Other conditions (Include pregnancy within 3 months of death) *III*

Major findings: *Dyspnoeic Pneumonia*

Of operations _____

Of autopsy *of Saban feet*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *with rucks*

(b) Date of occurrence _____

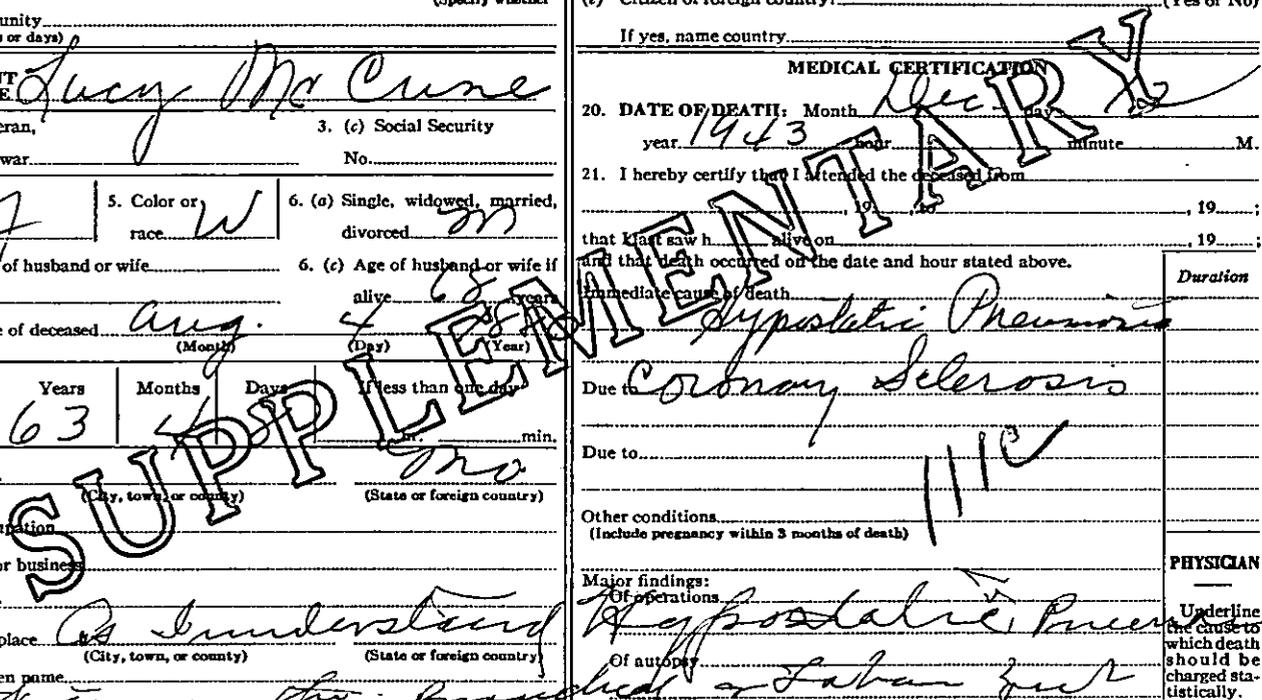
(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur (in or about home; on farm; in industrial place; in public place?) *at home*

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

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

Address _____ Date signed _____



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

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-43493