

FILED DEC 17 1943

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

43932

Do not use this space.

## 1. PLACE OF DEATH

(a) County Schuyler Registration District No. 325  
(b) Township ..... Primary Registration District No. 4478 Registered No. 97  
(c) City Lancaster (d) Street No. 1 St. Mo.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Lidia E. Parker  
(a) Residence, No. Lancaster, Mo. St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Esra Parker  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 6, 1876  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
67 3 23

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME George Kearsal

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

15. MAIDEN NAME Narcissa Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

17. INFORMANT (ADDRESS) Leona Turner

18. BURIAL, CREMATION, OR REMOVAL PLACE Armi Memorial DATE Nov 30 43

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Moreheads Lancaster Mo

20. FILED Nov. 30 1943 A. J. Justice Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 29 1943

22. I HEREBY CERTIFY, That I attended deceased from Sept 14 1943 to Nov 29 1943

I last saw her alive on Nov 12 1943. Death is said

to have occurred on the date stated above, at 5:58 a. m.

The principal cause of death and related causes of importance were as follows:

Cardiac Failure Date of onset

Other contributory causes of importance:

Asthma  
Chronic Bronchitis

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify.....

(Signed) R. E. Vaughan M. D.

(Address) Lancaster, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FORM 5-19 I X 16605

RECEIVED

District Health Officer No. 10

District File Number ~~12-43-2018~~ 12-43-2025

Date Filed DEC 15 1943

STATEMENT BY LICENSED EMBALMER

WA hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Irwin Minnie Marchand

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Marchand's

Licensed Embalmer No. 3731-3680

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, above space should be left blank.

Registration District No. 325 Primary Registration District No. 4478

1. PLACE OF DEATH:  
(a) County Schuyler  
(b) City or town Linnecaster  
(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)

3. (a) PRINT FULL NAME Lydian C. Locker  
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. w  
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive.

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

8. AGE: Years Months Days 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  
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 July 1943 year. 2:00 hour. 9 minute. M.  
21. I hereby certify that I attended the deceased from 9/3/43 to 9/3/43, 1943.  
that I last saw him alive on 9/3/43, 1943.  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cardiac Failure Duration

Chronic myocarditis  
Due to

934  
Due to

Other conditions asthma chronic  
(Include pregnancy within 3 months of death) Failure

Major findings:  
Of operations  
Of autopsy

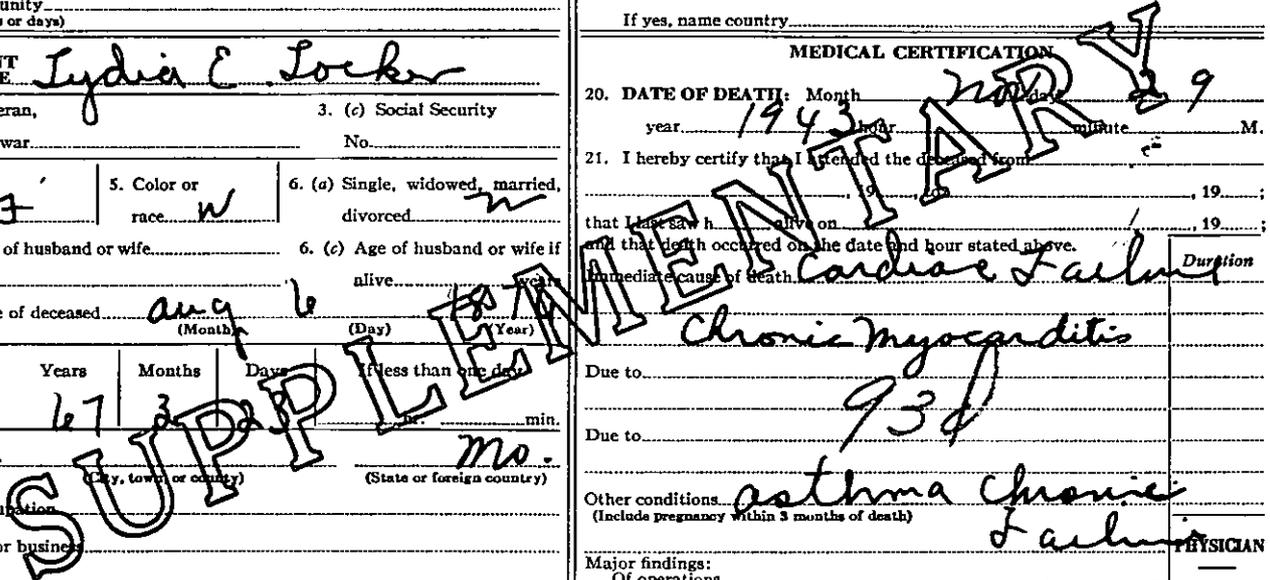
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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) Means of injury

23. Signature R.E. Vaughn (M. D. or other) D.O.  
Address Lancaster, Mo. Date signed

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



S-43932