

FILED JAN 10 1944  
Registration District No. 286

Primary Registration District No. 6207

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

1. PLACE OF DEATH:  
(a) County Texas  
(b) City or town Rural Lynchburg  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 8 yrs. (Month) (Year) (days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Texas  
(c) City or town Rural  
(If outside city or town limit write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Charles Fredrick Lancaster

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month Dec day 30  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

21. I hereby certify that I attended the deceased from MAY 10, 1940, to DEC 30, 1943

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

that I last saw him alive on DEC. 17, 1943  
and that death occurred on the date and hour stated above.

7. Birth date of deceased Sept 2 1871  
(Month) (Day) (Year)

Immediate cause of death APOPLEXY CEREBRAL

8. AGE: Years 72 Months 3 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to HYPERTENSIVE CARDIO-RENAL VASCULAR DISEASE

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Farmer

Major findings: Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Of autopsy \_\_\_\_\_

12. Name G. B. Lancaster

13/14

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

Underline the cause to which death should be charged statistically.

14. Maiden name Unknown  
(City, town, or county) (State or foreign country)

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

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

16. (a) Informant Luttie Lancaster (b) Address Houston Mo.

(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof Jan 1 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Wayford V. Elliott (b) Address Calhoun Mo.

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

19. (a) 1-4-44 (b) Mrs. Ella Buff  
(Date received local registrar) (Registrar's signature)

23. Signature J. G. Dillman (M. D. or other) M.D.

Address HOUSTON, MO Date signed 12-30

RECEIVED

District Health Officer No. 5,

District File Number 14430

Date Filed 11-7-46

---

---

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 Frank E. Hood

Licensed Embalmer No. 4024

P. O. Address Houston, 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, above space should be left blank.