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FILED FEB 14 1944

State File No. _____

Registration District No. 210

Primary Registration District No. 5769

Registrar's No. 2

1. PLACE OF DEATH:
 (a) County Mercer Co.
 (b) City or town Lindley Town ship
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: no
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no (Specify whether
 In this community all his life years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Mercer
 (c) City or town Rural (If outside city or town limits, write "RURAL")
 (d) Street No. 7th Princeton (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME William M. LaFollett
 3. (b) If veteran, name war no 3. (c) Social Security No. NO

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 3 year 1944 hour 9 - minute _____ M.
 21. I hereby certify that I attended the deceased from Dec 29, 1943 to Jan 3, 1944; that I last saw him alive on _____ and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Ellie LaFollett 6. (c) Age of husband or wife if alive 72 years
 7. Birth date of deceased Aug. 28, 1868 (Month) (Day) (Year)

Immediate cause of death Branches Pneumonia Duration 5 day
 Due to Senility ?
 Due to _____

8. AGE: Years Months Days If less than one day
76 4 6 hr. _____ min.
 9. Birthplace Indiana (City, town, or county) (State or foreign country)
 10. Usual occupation farmer

Other conditions Prostatic disease (Include pregnancy within 3 months of death) 443
 Major findings: Of operations 107 PHYSICIAN _____
 Of autopsy _____ Underline the cause to which death should be charged statistically.

MOTHER FATHER {
 11. Industry or business _____
 12. Name John LaFollett
 13. Birthplace unknown (City, town, or county) (State or foreign country) 9
 14. Maiden name unknown
 15. Birthplace unknown (City, town, or county) (State or foreign country) 9
 16. (a) Informant Clell LaFollett
 (b) Address Pleaston, Iowa
 17. (a) burial (Burial, cremation, or removal) (b) Date thereof Jan 4 1944 (Month) (Day) (Year)
 (c) Place: burial or cremation Freedom
 18. (a) Signature of funeral director Paul Snow
 (b) Address Funerary Hall
 19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 C. Snow (M. D. or other) no
 Address Princeton MO Date signed 1-3-44

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

1367

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed Paul Spear
Licensed Embalmer No. 2634
P. O. Address Cincinnati, Ohio

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. Feb.

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

1. PLACE OF DEATH:

(a) County Mersey
(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 _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Wm. M. LaFallett

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

4. Sex m 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 72 years

7. Birth date of deceased Aug. 25 (Month) (Day) (Year)

8. AGE: Years 76 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 1-15-44 (b) Ivan Mathis
(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 Jan day 1 year 1944 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 _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3579