

S. No. 2  
DM-2-43  
v. 5-17-39  
P. 1 X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6816

State File No. \_\_\_\_\_

FILED MAR 9 1944

Registration District No. 55

Primary Registration District No. 4082

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Bogard Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: No. 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 35 years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

(c) City or town Bogard  
(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 LENA LENOVA WAGAMAN

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14  
year 1944 hour 6 minute P.

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

21. I hereby certify that I attended the deceased from Feb 3 1944 to Feb 19 1944 that I last saw him alive on 2-13 1944 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married 2 divorced Widowed

Immediate cause of death: Bronchopneumonia

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased: FEB. 27. 1895  
(Month) (Day) (Year)

Due to Carcinoma of Brain

Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
48 11 17 hr. min.

Other conditions (Include pregnancy within 3 months of death) 54 lb

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

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

10. Usual occupation: House Keeper

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

12. Name: Charles Youmans

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

14. Maiden name: Wooden

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

16. (a) Informant: Mrs. Chas. Youmans  
(b) Address: Bogard, Mo.

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? \_\_\_\_\_

(c) Place: burial or cremation: Mr. Youmans

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director: E. A. Dickerson  
(b) Address: Bogard, Mo.

23. Signature: J. Y. Alcorn (M. D. or other) \_\_\_\_\_  
Address: Bogard, Mo. Date signed: 2/15/44

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

17  
0  
0

MOTHER FATHER

1055

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

Product File Number

Date Filed

3-8-44

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

*E. A. Dickerson*

Licensed Embalmer No.

2534

P. O. Address

*Bogard, 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.