

X29464

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21889

State File No.

FILED JUN 22 1944

Registration District No. 170

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Lebanon
(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 1
(Specify whether

In this community 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede 53

(c) City or town Lebanon 2
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME SARAH ELIZABETH JEFFERIES

3. (b) If veteran, name war:

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12th
year 1944 hour 2:00 A.M. minute

21. I hereby certify that I attended the deceased from 4/24/44
19... to 5/12/44 19...
that I last saw her alive on 5/10/44 19...
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Clayton Jefferies

6. (c) Age of husband or wife if alive 29 years
(Month) (Day) (Year)

7. Birth date of deceased Sept 29 1870
(Month) (Day) (Year)

Immediate cause of death Pneumonia ✓

Duration 3 weeks

8. AGE: Years Months Days If less than one day

73 7 13 hr. min.

Due to:

Due to:

Other conditions Cardiac Deomyositis Unk.
(Include pregnancy within 3 months of death)

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

10. Usual occupation Housewife

11. Industry or business:

12. Name Zachariah DeGraffenheid

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

14. Maiden name Sabra Snelling

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

16. (a) Informant Mrs Betsy Ann Warden

(b) Address Ullman Mo.

17. (a) Burial (b) Date thereof 5-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery Lebanon

18. (a) Signature of funeral director W.E. Holman

(b) Address Lebanon Mo.

19. (a) 5-15-44 (b) Grace Roper
(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?

(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 John M. Peckham M.D.
Address Laclede County Health Unit Lebanon, Mo.
dated 5/12/44

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

2-3

MOTHER FATHER

1090

Received

Laclede County Health Unit

File No. 5-44-60

Date Filed 6/21/74

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 *Dorsey M. Howe*

Licensed Embalmer No. *4222*

P. O. Address *Lebanon, 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. July
Registrar's No. _____

Registration District No. 110

Primary Registration District No. 2023

1. PLACE OF DEATH:

(a) County Isle de Jebeanon
(b) City or town _____
(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 Luah E. Jefferies

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 _____

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

7. Birth date of deceased Sept 29 (Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 2 (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 _____ (State or foreign country)

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

16. (a) Informant _____

(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 May day 12 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death: pneumonia

tabac pneumonia Duration? 3 weeks

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed 6-26-44

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

SUPPLEMENTARY

21889