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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 11 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 132

Primary Registration District No. 5480

Registrar's No. 302

1. PLACE OF DEATH:

(a) County Gundy

(b) City or town Rural # 3 Newton Township
(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) 1

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community all life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Gundy ⁴⁰

(c) City or town Rural # 3 Newton Township
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME JAMES CLARK LEHOW

3. (b) If veteran, name war NO

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1944 hour 3 minute 45 p.M.

4. Sex MO 5. Color or race white

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

6. (b) Name of husband or wife Ella M. LeHow

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased: may 16 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 1, 1944 Sept 2, 1944
that I last saw him alive on Sept 1, 1944
and that death occurred on the date and hour stated above.

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

74 3 17 hr. min.

Immediate cause of death Chronic interstitial nephritis 5 mo

Due to _____

Due to _____

9. Birthplace Fort Wayne Ind
(City, town, or county) (State or foreign country)

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

Major findings: 131a

Of operations _____

Of autopsy _____

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER

12. Name Benjamin F. LeHow

13. Birthplace Scott Run W
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Coughlin

15. Birthplace Scott Run W
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Nassie LeHow

(b) Address Route 3, Trenton, Mo.

17. (a) Burial (b) Date thereof Sept 4-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rural # 3 Newton Township

18. (a) Signature of funeral director J. H. Helge

(b) Address 1414 S. Main St. Trenton

19. (a) Sept. 4, 1944 (b) L. S. Roberts
(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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature J. H. Helge (M. D. or _____)
Address Trenton Mo. Date signed 9/1/44

1320

(Licensed Embalmer's Statement on Reverse Side)

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

000

JUL 27 1961

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.....

John M. Robertson....., Registered Apprentice No. 353
working under my personal supervision.

Signed E. J. Robertson.....

Licensed Embalmer No. 2465.....

P. O. Address Fareed, 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.