

No. 2
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-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41837**
Registrar's No. **411**

FILED JAN 10 1944
Registration District No. **2494**

Primary Registration District No. **3052**

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

1. PLACE OF DEATH:

(a) County **Pettis**

(b) City or town **Sedalia**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Bothwell Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days** (Specify whether years, months or days) **0**

In this community **0**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Morgan** **71**

(c) City or town **Versailles** **(rural)** **0**
(If outside city or town limits, write "RURAL")

(d) Street No. **RFD # 3.** (If rural, give location) **0**

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

3. (a) PRINT FULL NAME **Lewis Edgar Igo**

3. (b) If veteran, name war **0**

3. (c) Social Security No. **0**

4. Sex **Male** **0** 5. Color or race **White**

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

6. (b) Name of husband or wife **Lucy**

6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **Nov. 30 1894**
(Month) (Day) (Year)

8. AGE: Years **50** Months **-** Days **17** If less than one day hr. **0** min. **0**

9. Birthplace **Morgan Co. Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

MOTHER, FATHER

11. Industry or business **0**

12. Name **Leonidas Igo**

13. Birthplace **Cooper Co. Mo. 0**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret G. Beaman**

15. Birthplace **Cooper Co. Mo. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lucille Lane**

(b) Address **Windsor, Mo.**

17. (a) **Burial** (b) Date thereof **12/19/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Glenstead, Mo.**

18. (a) Signature of funeral director **Gillespie Funeral Home**

(b) Address **Sedalia, Mo.**

19. (a) **12/19/44** (b) **Mrs. Anna Berger**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **17** year **1944** hour **4** minute **40 A.** M.

21. I hereby certify that I attended the deceased from **Dec. 14** 19**44** to **Dec. 17** 19**44**
that I last saw him **0** alive on **Dec. 16** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** **4 da** **Duration**

Due to **Arterio Sclerosis**
Hypertension

Due to **0**

Other conditions **0**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **0**

Of autopsy **0**

PHYSICIAN **0**
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) **0**

(b) Date of occurrence **0**

(c) Where did injury occur? (City or town) (County) (State) **0**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **0**

While at work? **0** (Specify type of place) Means of injury **0**

23. Signature **W. T. Boyer** (M. D. or other) **0**

Address **Sedalia Mo.** Date signed **12-18-44**

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-2-45

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

Geo. Dillard

Licensed Embalmer No.

3868

P. O. Address

Subalia

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.