

FILED FEB 14 1945

Registration District No. **1764** Primary Registration District No. **6258** Registrar's No. _____

500
 WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Lawrence
 (b) City or town Rural (Vineyard 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)
 (d) Length of stay: In hospital or institution _____
 In this community 19 months (Barton County 29 yrs)
years, months or days (Specify whether years, months or days)

3. (a) PRINT FULL NAME STEPHEN HARRISON LADY
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex Male **5. Color or race** White **6. (a) Single, widowed, married, divorced** Divorced
6. (b) Name of husband or wife Lydia Dillon **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased: August 27 1853
(Month) (Day) (Year)

8. AGE: Years 91 Months 4 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation: Carpenter-Retired

11. Industry or business _____

MOTHER FATHER
12. Name: Unknown
13. Birthplace: Unknown
(City, town, or county) (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Austin Smith
(b) Address: Sarcoxie, Missouri. RFD #2

17. (a) Burial: Howell Cemetery **(b) Date thereof:** Jan 19 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Barton County, Missouri
KONANTZ FUNERAL HOME

18. (a) Signature of funeral director: _____
(b) Address: Lamar, Missouri

19. (a) 1-22-45 **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County: Lawrence **\$5**
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. RFD #2-Sarcoxie
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 17th
 year 1945 hour 10 minute 30 P.M.
21. I hereby certify that I attended the deceased from Dec 1943
 _____, 19____, to Jan 17th, 1945
 that I last saw him alive on Jan 16, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac and Respiratory Failure Duration
 Due to Coronary Thrombosis
 Due to chronic valvular insufficiency and Decompenation
 Other conditions Senility
(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? _____

23. Signature: Dr. H. Kilbire (M.D. or other) **Dr.**
 Address Sarcoxie Mo Date signed Jan 19 45
(Specify type of place) (e) Means of injury

RECEIVED

District Health Officer No. 6

District File Number 245-206

Date Filed FEB 13 1945

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.....

Carl F. Monantz

Licensed Embalmer No. 2247

P. O. Address Lamar, Missouri

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.