

FILED MAR 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Howell 64779
State File No. _____
Registrar's No. _____

Registration District No. 170

Primary Registration District No. 3033

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: WALLACE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ABOUT 1 WK.
(Specify whether
In this community 3 mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE
(c) City or town LEBANON 53
(If outside city or town limits, write "RURAL")
(d) Street No. HAYS & MADISON 1
(If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME PAUL L. FORDON

3. (b) If veteran, name war 1ST & 2ND WORLD WAR 3. (c) Social Security No. 569-30-2504

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife BERNIECE FRY 6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased JUNE 17 1897
(Month) (Day) (Year)

8. AGE: Years 47 Months 8 Days _____ If less than one day
hr. _____ min. _____

9. Birthplace FAIRPLAY MO
(City, town or county) (State or foreign country)

10. Usual occupation STATE SALES TAX, DEPT.

11. Industry or business

12. Name R. D. FORDON
13. Birthplace BOLIVAR MO
(City, town, or county) (State or foreign country)
14. Maiden name CARDIE HEDRICK
15. Birthplace BOLIVAR MO
(City, town, or county) (State or foreign country)

16. (a) Informant My P. L. Gordon
(b) Address Lebanon Mo

17. (a) Burial (b) Date thereof 2-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BOLIVAR

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) 2-24-45 (b) Grace Cape
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 17
year 1945 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from 2-11-1945 to 2-17-1945
that I last saw him alive on 2-16-1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 9 days

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 R. E. Howell (M. D. or other) MD
Address Lebanon, Mo Date signed 2-20-45

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

1
2

Received

Laclede County Health Unit

File No. 2-45-12

Date Filed 3/9/45

JAN 21 1945

APR 25 1945

MAR 10 1945

MAR 20 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 *D. Bohner*

Licensed Embalmer No. 1161

P. O. Address *L. Moran*

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.