

2-43  
6-17-39  
X35697

FILED MAY 1-1945

State File No. \_\_\_\_\_

Registration District No. 20

Primary Registration District No. 4031

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Adrian  
(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 6 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates

(c) City or town Adrian  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME LouDeamy Lothridge

3. (b) If veteran, name war. X

3. (c) Social Security No. X

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife J. M. Lothridge

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased May 17 1861  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>11</u>	<u>13</u>	hr. _____ min. _____

9. Birthplace Summerset Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name John Wesley Cox

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

14. Maiden name Lou Rissia Thompson

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

16. (a) Informant Daisy Stephenson

(b) Address Archie Mo.

17. (a) Burial (b) Date thereof 5 2 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crescent Hill Cem.

18. (a) Signature of funeral director Leuth + Dix

(b) Address Adrian Mo.

19. (a) 5-1-45 (b) Blanchette  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30  
year 1945 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from Mar. 28, 1945, to April 25, 1945.

that I last saw h<sub>e</sub>r alive on April 27, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis and diabetic Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 E. E. Robinson (M. D. or other) \_\_\_\_\_

Address Adrian, Mo. Date signed 5-1-45

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

1299

RECEIVED

District Health Officer No. 7,

District No. Number 4-45-436

Date Filed 6-10-45

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 *and*

*Fred J. Leath 3343*

Registered Apprentice No.

working under my personal supervision.

Signed

*Adrian M.*

Licensed Embalmer No. *3650*

P. O. Address *Adrian M.*

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. May  
Registrar's No. 6

Registration District No. 20 Primary Registration District No. 4031

1. PLACE OF DEATH:  
(a) County Bates  
(b) City or town Adrian  
(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 Lou Deamy Lethridge  
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 m  
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years

7. Birth date of deceased May 17  
(Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days 1 (If less than one day, in 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 (City, town, or county) (State or foreign country)

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

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director. (b) Address

19. (a) (Date received local registrar) (b) (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 April day 20  
year 1946 hour 12 minute 0 M.  
21. I hereby certify that I attended the deceased from 1946 to 1946,  
that I last saw him alive on April 20, 1946,  
and that death occurred on the date and hour stated above.

Immediate cause of death chronic nephritis  
diabetes  
Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death) 61

PHYSICIAN  
Major findings: none performed  
Of operations  
Of autopsy none  
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) none  
(b) Date of occurrence none  
(c) Where did injury occur? none  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
none  
While at work? (Specify type of place) (e) Means of injury

23. Signature E.E. Robinson (M. D. or other)  
Address Adrian, Mo Date signed 5-12-46

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

SUPPLEMENTARY

12760