

FILED JUN 21 1945
Registration District No. **170**

Primary Registration District No. **2001-3033**

1. PLACE OF DEATH:

(a) County **GREENE LACLEDE**
(b) City or town _____
(c) Name of hospital or institution: **WALLACE Hospital**
(d) Length of stay: In hospital or institution **30 days**
In this community **60 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Laclede**
(c) City or town **Steuilard Mo.**
(d) Street No. _____
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **WILLIAM HENRY WHITE**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **Alice Maggier** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **MARCH 19 1864**

8. AGE: Years **81** Months **1** Days **20** If less than one day _____ hr. _____ min.

9. Birthplace **CARROLL MO**

10. Usual occupation **CARDNER**

11. Industry or business _____

12. Name **OLIVER WHITE**

13. Birthplace **HI. K**

14. Maiden name **WILSON**

15. Birthplace **HI. K**

16. (a) Informant **Max F. D. Kelly**

(b) Address **Springfield Mo**

17. (a) **Burial** (b) Date thereof **May 45**

(c) Place: burial or cremation **Springfield Mo**

18. (a) Signature of funeral director **Edward D. ...**

(b) Address **Springfield Mo**

19. (a) **June 11-45** (b) **Grace Roper**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **9** year **19** hour **3:45** minute **9** a. m.

21. I hereby certify that I attended the deceased from **5/1/45** to **5/8/45**
that I last saw him alive on **5/8/45** and that death occurred on the date and hour stated above.

Immediate cause of death **uremia**
Due to **Hypertension**

Due to _____

Other conditions (Include pregnancy within _____ of death) _____

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
Of operations _____
Of autopsy _____

Duration

7 days

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 **James P. Hope** (M. D.)
Address **Steuilard, Mo** Date signed **5/1/45**

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

Received _____

Laclede County Health Unit

File No. 5-45-62

Date Filed 6/19/45

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

W. D. Palmer

Licensed Embalmer No. 1161

P. O. Address Bellevue Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 170

Primary Registration District No. 3083

1. PLACE OF DEATH:
 (a) County Los Angeles
 (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 _____ (Specify whether _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME Mr Henry White
 3. (b) If veteran, name war _____
 (c) Social Security No. _____

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Mar 19 (Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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

16. (a) Informant _____
 (b) Address _____

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

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

19. (a) 7-10-45 (b) Grace Roper
 (Date received local registrar) (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 July Day _____ Year 1945 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____, that I last saw him _____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
 Due to Chronic Nephritis unk.
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

Duration _____
 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 James L. Hope (M. D. or other) Lebanon, Mo. Date signed 7/10/45
 Address _____

SUPPLEMENTARY

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

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