S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25204

FILED AUG 6 1945

Registration District No. 529 Primary Registration District No. 4485 6112A Registrar's No. 52

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Commerce or Kelso-Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Route 1 Twp
(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) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott 10

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 4 miles N.East Benton, Mo. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME August Pias Ledure

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 Widowed

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Oct (Month) 27 (Day) 1876 (Year)

8. AGE: Years 68 Months 8 Days 26 If less than one day ..... hr. ..... min.

9. Birthplace St. Genevieve (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Farmer

11. Industry or business —

FATHER
12. Name August Ledure
13. Birthplace France (City, town, or county) (State or foreign country) 5

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant Ben Ledure
(b) Address Commerce - Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-45 (Month) (Day) (Year)
(c) Place: burial or cremation Kelso Mo

18. (a) Signature of funeral director Joe G Howell
(b) Address Cape Girardeau Mo

19. (a) July 29 1945 (Date received local registrar) (b) Mrs W. L. Tomlinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1945 hour ..... minute 9 A: M.

21. I hereby certify that I ~~attended~~ VIEWED the deceased from ..... 19.. to July 23 1945 that I last saw h... alive on ..... 19.. and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Choked to death	
Due to Suicidal Hanging	
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) Suicide
(b) Date of occurrence 7-23-45
(c) Where did injury occur? Scott Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Barn at Home (Specify type of place)
While at work? (e) Means of injury ?

23. Signature Orville Taylor Coroner (M. D. or other)
Address Sikeston, Mo Date signed 7-23-45

1316

(Licensed Embalmer's Statement on Reverse Side)

JUN 6 1965

RECEIVED
District Health Office No. 2
District File Number 85-164
Date Filed 8-3-65

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 J. E. Howell

Licensed Embalmer No. 3390

P. O. Address Cope

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.