

No. 1-543
5-17-39
X36671

State File No. _____
Registrar's No. _____

FILED NOV 27 1945
Registration District No. _____

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 Memorial Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede 53
(c) City or town Conway
(If outside city or town limits, write "RURAL")
(d) Street No. R# 1
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Oscar Fitzellen Ponder
(b) If veteran, name war none
(c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 19
year 1945 hour 7 minute _____ P. M.
21. I hereby certify that I attended the deceased from 9/13
1945 to 9/19 1945
that I last saw him alive on 9/19 1945
and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mary L. Ponder
6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased April 12 1856
(Month) (Day) (Year)

Immediate cause of death:
chronic nephritis unk
Due to prostatic hypertrophy unk
Due to urinary retention of bladder 10 days
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years Months Days If less than one day
89 5 7 hr. _____ min.

9. Birthplace Iberia mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Retired farmer

11. Industry or business _____
12. Name Winslow Ponder
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name Jean Robinson
15. Birthplace Penn. 1
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy 131b
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
16. (a) Informant Mrs Hazel Ponder
(b) Address Lebanon mo
17. (a) Burial (b) Date thereof 9-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bear Thicket
18. (a) Signature of funeral director W.E. Holman
(b) Address Lebanon mo
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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)
(b) Means of injury _____
23. Signature Jung S. Hops (M. D. or other) _____
Address Lebanon mo Date signed 9/27/45

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

Received

Laclede County Health Unit

File No. 10-45-142

Date Filed 11/15/43

MAR 24 1949

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 *Jersey M. Howe*

Licensed Embalmer No. 4222

P. O. Address *Lebanon, Mo.*

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.

Registration District No. 170 Primary Registration District No. 3023

1. PLACE OF DEATH:

(a) County Fosberg

(b) City or town Lebanon
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Oscar F. Pender

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 m

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

7. Birth date of deceased Apr 12
(Month) (Day) (Year)

8. AGE: Years 89 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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) Oct. 10, 1943 (Date received local registrar) (b) Ora H. Frankenberg (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 _____, Year 1943, Hour _____, Minute _____, M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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) _____

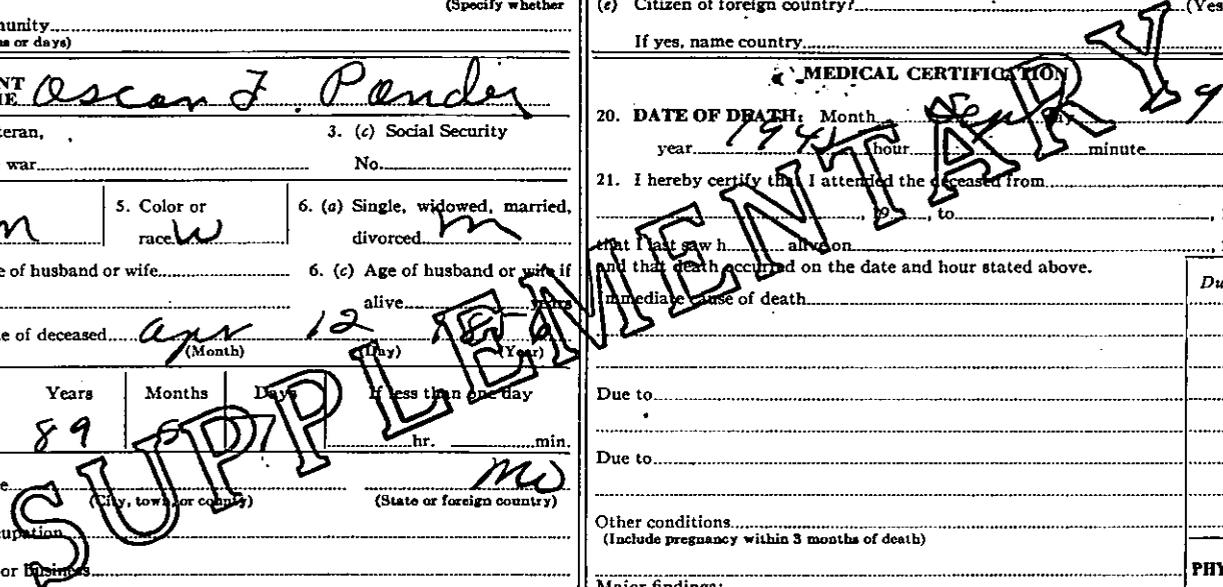
(b) Date of occurrence _____

(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 _____ (M. D. or other) _____ Date signed _____



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

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