

8-43
17-39
X37623

FILED JAN 21 1946
Registration District No. 174

Primary Registration District No. 3035

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Luxington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1811 South St 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette
(c) City or town Luxington
(If outside city or town limits, write "RURAL")
(d) Street No. 1811 South St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GLADYS GWILLIA

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased April 3 - 1909
(Month) (Day) (Year)

8. AGE: Years 36 Months 8 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name James Biggs

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

14. Maiden name Zada Fieldcamp

15. Birthplace Ill 1
(City, town, or county) (State or foreign country)

16. (a) Informant James Biggs

(b) Address Luxington MO

17. (a) Burial (b) Date thereof 12-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Luxington MO

18. (a) Signature of funeral director James E. Engel

(b) Address Luxington MO

19. (a) 12 January (b) Wm. E. Eastaloms
(Date received local registration) (Registrar's signature)

20. DATE OF DEATH: Month Dec day 26
year 1945 hour 2 minute 4 M.

21. I hereby certify that I attended the deceased from as coroner 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 Acute cerebral & pulmonary edema (cause undetermined)
Due to pending further investigation
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____

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) (c) Means of injury _____

23. Signature W. Keppel (M. D. or other) MD
Address Niggin'sville MO Date signed 1/26/46

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

1-15-46

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..... *Geo M. Pease*.....
Licensed Embalmer No. *2983*.....
P. O. Address..... *Leighton 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 174

Primary Registration District No. 3035

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Safayette
(b) City or town Lexington
(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

Gladys Guilha

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 div

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

7. Birth date of deceased Apr. 3 (Month) (Day) (Year)

8. AGE: Years 36 Months _____ Days _____ (If less than one day) hr. _____ 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 _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 _____ year 1946 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 acute pulmonary edema
cerebral edema
Due to over dose of barbiturates.
Due to _____

Duration

Autem

Other conditions. (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy See above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Dec 26-1946

(c) Where did injury occur? Lexington (City or town) (County) (State) MO

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? _____ (Specify type of place) (c) Means of injury Medicine

23. Signature W. Koppert (M. D. or other) _____

Address Highway 111, Mo. Date signed 1/13/46
Coroner, Lexington

SUPPLEMENTARY

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

100516

3120