

FILED FEB 7 1946  
Registration District No. 173

Primary Registration District No. 4274

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

Registrar's No. 81

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Auville  
(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 1 month  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette  
(c) City or town Anllville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John William Need

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

4. Sex M O 5. Color or race White 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife Sarah Merriot Need 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Dec. 10 1878  
(Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 10  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Gravois Mills, Mo.  
(City, town, or county) (State or foreign country)  
Farmer

10. Usual occupation \_\_\_\_\_

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

12. Name Leonard Need

13. Birthplace not known  
(City, town, or county) (State or foreign country)

14. Maiden name Louise Morris  
not known

15. Birthplace not known  
(City, town, or county) (State or foreign country)

16. (a) Informant Nona Dougherty

(b) Address Auville, Mo.

17. (a) Burial (b) Date of burial Jan 22 1946  
(Month) (Day) (Year)

(c) Place: burial or cremation Stover, Mo.

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address Higginsville, Mo.

19. (a) Jan 21 1946 (b) Ferdinand Shryman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20  
year 1946 hour 8 minute A.M.

21. I hereby certify that I attended the deceased from Jan 19 1946 to Jan 20 1946  
that I last saw him alive on Jan 19 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis  
Due to Asma

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? \_\_\_\_\_

(Specify type of place)  
(While at work?) \_\_\_\_\_ (Means of injury) \_\_\_\_\_  
23. Signature Leonard Dougherty  
Address Higginsville, Mo. Date signed Jan 21 1946

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 2-5-46

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 Forrest S. Hooper

Licensed Embalmer No. 04358

P. O. Address Higginsville

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. 173

Primary Registration District No. 4274

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Lawville  
(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

John W. Reed

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 \_\_\_\_\_ years

7. Birth date of deceased Dec 10 (Month) (Day) (Year)

8. AGE: Years 75 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 \_\_\_\_\_

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 \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Jan 21-1946 (b) Donald Shyman (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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I autopsied \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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) \_\_\_\_\_

(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) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

1413

3134