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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 15 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5327

State File No. _____

Registration District No. 132

Primary Registration District No. 3021

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Grundy

(b) City or town Princeton Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Cullom Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 hrs (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Grundy 40

(c) City or town Galt 1
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No) ✓
If yes, name country _____

3. (a) PRINT FULL NAME LAYLAUGHN L ELWOOD

3. (b) If veteran, name war World War II

3. (c) Social Security No. 486 12 7402

4. Sex Male 0 5. Color or race Wh

6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased Oct - 12 - 1914
(Month) (Day) (Year)

8. AGE: Years 31⁺ Months 3 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Humphreys Mo 17
(City, town, or county) (State or foreign country)

10. Usual occupation Labour & Saldin

11. Industry or business _____

12. Name _____

13. Birthplace Galt Mo 9
(City, town, or county) (State or foreign country)

14. Maiden name Callie Elwood

15. Birthplace Humphreys Mo 17
(City, town, or county) (State or foreign country)

16. (a) Informant Dewain Elwood

(b) Address Galt Mo

17. (a) Burial (b) Date thereof Feb 5 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galt Cemetery

18. (a) Signature of funeral director W. J. Payne, Son

(b) Address Galt Mo

19. (a) 2-11-46 (b) Dewain Elwood
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3
year 1946 hour 111 minute 20

21. I hereby certify that I attended the deceased from Jan 3 1946 to Feb 3 1946
that I last saw him alive on Feb 3 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of skull & some internal injuries
Due to accident 8 hrs Duration

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accidental

(b) Date of occurrence 2/3/46 10

(c) Where did injury occur? Princeton Mo
(City or town) (County) (State)

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

While at work? Probably (Specify type of place) (e) Means of injury auto

23. Signature Dewain Elwood (M. D. 0)
Address Princeton Mo Date signed 2/4/46

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

MOTHER FATHER

MAR 19 1945
MAR 27 1945
MAR 26 1945

MAR 22 1945

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 P. K. Payne Jr
Licensed Embalmer No. 3400
P. O. Address Galt

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. May
Registrar's No. _____

Registration District No. 132 Primary Registration District No. 3021

1. PLACE OF DEATH:
(a) County Sturdy
(b) City or town Sturdy
(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 Laurie Lynn L. Elwood
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 s
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 12 1949
(Month) (Day) (Year)

8. AGE: Years 31 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 _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

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 1949 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 struck by passing auto
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy 170C-8 21

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) accident
(b) Date of occurrence 7/27/49
(c) Where did injury occur? 7th Precinct Mo (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, farm, in industrial place, in public place? Washburn Mo Co
While at work? _____ (Specify type of place) (c) Means of injury auto
23. Signature EJ Travis (M. D. or other) _____
Address _____ Date signed 7/27/49

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

SUPPLEMENTARY 3

4323

MAY 27 1965

5327