

No. 5-43
17-39
X36871

FILED APR 10 1946

State File No. _____

Registration District No. 44

Primary Registration District No. 4061

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Bragner Mo.
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State mo. (b) County Caldwell

(c) City or town Bragner mo
(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 _____

3. (a) PRINT FULL NAME Mission Johnson Luckins

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

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 March 1 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>0</u>	<u>23</u>	_____ hr. _____ min.

9. Birthplace Athens Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant Miss Edith Stone

(b) Address Bragner mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 26 1946
(Month) (Day) (Year)

(c) Place: burial or cremation Council mo

18. (a) Signature of funeral director Ch. H. Leland

(b) Address Council mo

19. (a) Margaret Joan Mills (Date received local registrar) (b) John R. Crank (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
year 1946 hour 3 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from March 16, 1946, to March 24, 1946
that I last saw him alive on March 23, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 24 hrs

Due to Arteriosclerosis unknown

Due to Chronic Interstitial Nephritis unknown

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

Major findings: _____

Of operations _____

Of autopsy 1310

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)

(c) Means of injury: _____

23. Signature John R. Crank M. D. or other _____

Address Bragner, Mo. Date signed 3/25/46

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

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.....

Ch Reed

Licensed Embalmer No. 2194

P. O. Address Cougler, 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. April
Registrar's No. 7

Registration District No. 44 Primary Registration District No. 4061

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Braymer
(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

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 _____

3. (a) PRINT FULL NAME William J. Luker
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
(b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased mar (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Edith Stone
(b) Address Braymer mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Courier mo

18. (a) Signature of funeral director Ch H Reed
(b) Address Courier mo

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

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 _____

Due to _____
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) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

7622

SUPPLEMENTARY

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

8691