

**FILED** APR 17 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. **13712**

Registration District No. **174**

Primary Registration District No. **3035**

Registrar's No. **9720**

**1. PLACE OF DEATH**

(a) County Lafayette  
(b) City or town Lexington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2015 Monroe 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 80 yrs  
years, months or days

3. (a) PRINT FULL NAME WILLIAM C. HERD

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

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

6. (b) Name of husband or wife Catherine G. Herd 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 25 1858  
(Month) (Day) (Year)

8. AGE: Years 88 Months 1 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

11. Industry or business Laborer

12. Name not known

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

14. Maiden name not known

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

16. (a) Informant Mrs. Gaiust Wallace

(b) Address Lexington, MO

17. (a) Burial (b) Date thereof 3-27-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, MO

18. (e) Signature of funeral director Gaiust Pumpel

(b) Address Lexington, MO

19. (a) 5 April 1946 (b) William C. Herd  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County Lafayette  
(c) City or town Lexington  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2015 Monroe  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar day 25  
year 1946 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from 14 Feb 1946 to 25 Mar 1946  
that I last saw him alive on 24 Mar 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure

Due to arteriosclerotic heart disease 10 yrs  
Due to senility 15 yrs

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 E. J. Wallace (M. D. or other)  
Address LEXINGTON, MO Date signed 3/25/46

Duration

IMMEDIATE

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
12616

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

4-15-46

Waller

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. McLean*

Licensed Embalmer No. 2983

P. O. Address *Washington*

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.