

**FILED JUN 14 1946 STANDARD CERTIFICATE OF DEATH**

State File No. **17104**

Registration District No. **169**

Primary Registration District No. **4258**

Registrar's No. **40**

**1. PLACE OF DEATH:**  
 (a) County **Knox**  
 (b) City or town **Edina**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Gibson Hospital. 0**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **17 days**  
 In this community **55 yrs.** (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** **Walter William Lanham**  
**3. (b) If veteran, name war**  
**3. (c) Social Security No.** **486-14-1992**

**4. Sex** **M** **5. Color or race** **W**  
**6. (a) Single, widowed, married, divorced** **Married**  
**6. (b) Name of husband or wife** **Maude L. Lanham**  
**6. (c) Age of husband or wife if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** **April - 19 - 1885**  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>61</b>	<b>4</b>	<b>16</b>	hr. min.

**9. Birthplace:** **Sangamon County, Illinois**  
 (City, town, or county) (State or foreign country)

**10. Usual occupation:** **farmer**

**11. Industry or business:**  
**12. Name** **Thomas Lanham**  
**13. Birthplace** **Sangamon County, Illinois**  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** **Eliza Judd**  
**15. Birthplace** **Sangamon County, Illinois**  
 (City, town, or county) (State or foreign country)

**16. (a) Informant** **Walter W. Lanham**  
**(b) Address** **LaBelle**

**17. (a) Burial** (b) Date thereof **May-12-1946**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** **Linville, Edina, MO.**

**18. (a) Signature of funeral director** **Keith Hudson**  
**(b) Address** **Edina, Missouri**

**19. (a) May-14-46** (b) **Nelle S. Nunn**  
 (Date recorded local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Missouri** (b) County **Lewis 56**  
 (c) City or town **LaBelle 0**  
 (If outside city or town limit, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years **1**

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **May** day **9**  
 year **1946** hour **10** minute **20** a.m.

**21. I hereby certify that I attended the deceased from** **4/20**  
 \_\_\_\_\_, 1946, to **5/9**, 1946,  
 that I last saw him alive on **5/9**, 1946,  
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocardial infarction**  
 Due to: **Myocardial infarction**  
 Due to: \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
 Major findings: Of operations: **870**  
 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) (e) Means of injury \_\_\_\_\_

**23. Signature** **W. W. Lanham** (M., D. or other)  
**Address** **Edina** **Date signed** **5/12/46**

Duration **20 days**  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

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

15985

344

RECEIVED

District Health Officer No. 10

District File Number 6-46-12

Date Filed JUN 13 1946

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 John Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Minn.

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, above space should be left blank.

Registration District No. 169

Primary Registration District No. 4259

1. PLACE OF DEATH:

(a) County Knox  
(b) City or town Edwina  
(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

Walter W. Farhan

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

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

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

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

MOTHER FATHER

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

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

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 May day \_\_\_\_\_ year 1949 hour \_\_\_\_\_ minute 05 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her \_\_\_\_\_, 19\_\_\_\_; 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 Edwina Date signed 4/7-46

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

SUPPLEMENTARY

17104