

18-43
-17-39
X37823

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

Registration District No. 186

Primary Registration District No. 2007

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper

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

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

(d) Length of stay: In hospital or institution 1 day
(Specify whether)

In this community 3 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Webb City 6
(If outside city or town limits, write "RURAL")

(d) Street No. 814 N 1st 2
(If rural, give location)

(e) Citizen of foreign country? No. 1
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Daisy Lee Pegler

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex F 1. Color or race W

6. (a) Single, widowed, married, divorced 1

(b) Name of husband or wife W. O. Pegler

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

7. Birth date of deceased Feb 16 1882
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days - If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Lane

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

14. Maiden name Haney Murray

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

16. (a) Informant W. O. Pegler

(b) Address Webb City, Mo.

17. (a) Burial (b) Date thereof 6/17/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springdale, Ark.

18. (a) Signature of funeral director Edgar Lewis

(b) Address Webb City, Mo.

19. (a) 6-18-46 (b) Ed D. James
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased (from June 14
1946 to June 16, 1946)
that I last saw her alive on June 16, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Broncho
pneumonia Duration
Probably Influenza 2 days
Probably Influenza 1 week

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy 7-3-46

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

22. If death was due to external causes, fill in the following:

(c) 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? Yes (Specify type of place) _____

(c) Means of injury _____

23. Signature Ed D. James (M. D. or other) _____

Address Webb City, Mo. Date signed 6/17/46

46-6-562

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.....

Richard H. Lewis

Licensed Embalmer No.

4405

P. O. Address.....

Webb City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. Aug
Registrar's No. _____

Registration District No. 156 Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin
(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 Daisy L. Ziegler

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

4. Sex F 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 Feb 16 (Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days _____ (Unless than one day) yr. min.

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

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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-18-46 (b) [Signature] (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 July year 1946 hour 12 minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her 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 _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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