

No. 2
M-8-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43243**
Registrar's No. **44**

FILED JAN 14 1947
Registration District No. **374**

Primary Registration District No. **4548**

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

1. PLACE OF DEATH:

(a) County **Worth County**
(b) City or town **Worth**
(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 **78 yrs** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **M. L. Lathrum**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Nellie Lathrum** 6. (c) Age of husband or wife if alive **78** years
7. Birth date of deceased **July 30 1868**
(Month) (Day) (Year)

8. AGE: Years **78** Months **4** Days **22** If less than one day hr. min.

9. Birthplace **Clay County Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **produce Dealer**

11. Industry or business
12. Name **John Lathrum**
13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Barbara Atkinson**
15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Blanche Wallace**
(b) Address **Worth MO**
17. (a) **Burial** (b) Date thereof **Dec 25-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Fairview**

18. (a) Signature of funeral director **Hayes Andrews**
(b) Address **Worth Mo**
19. (a) **Dec 29-46** (b) **Leta E. Dawson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Worth** 113
(c) City or town **Worth** 0
(If outside city or town limits, write "RURAL")
(d) Street No. **0** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month **December** day **21**
year **1946** hour **5 A.M.** minute **0** M.

21. I hereby certify that I attended the deceased from **Sept 10**
46 to **Dec 21**, 19**46**;
that I last saw him alive on **46 Dec 20**, 19**46**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic arteriosclerosis of the heart**
Duration **2 1/2 yrs**

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **7310**
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) (c) Means of injury **0**

23. Signature **S. H. Hest MD** (M. D. or other) **0**
Address **Worth Mo** Date signed **12/21/46**

LEGAL F. B.

**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..... *[Handwritten Signature]*

Licensed Embalmer No..... *2593*

P. O. Address..... *[Handwritten Address]*

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. Jan
Registrar's No. 44

Registration District No. 37A

Primary Registration District No. 4548

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Worth
(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 M. L. Latham

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 Married

6. (b) Name of husband or wife Wife 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased July 30
(Month) (Day) (Year)

8. AGE: Years 78 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 _____ Day _____
Year 1946 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I has seen him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediately 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 _____ Date signed _____

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

SUPPLEMENTARY

S-43343