

FILED JUL 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20443

Registration District No. 96

Primary Registration District No. 5356

Registrar's No. 42

1. PLACE OF DEATH:

(a) County DALLAS
 (b) City or town LONGLANE RURAL
 (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 7 YRS
years, months or days)3. (a) PRINT FULL NAME MARTIN VAN BUREN CAUGHRAN

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife LILLIE 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased SEPT 6 - 1896
 (Month) (Day) (Year)

8. AGE: Years 60 Months 8 Days 15 If less than one day
 hr. _____ min. _____

9. Birthplace DALLAS CO MO
 (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

12. Name WF CAUGHRAN
 13. Birthplace MARSH TENN
 (City, town, or county) (State or foreign country)
 14. Maiden name MARGRET WILLIAMS
 15. Birthplace WEBSTER MO
 (City, town, or county) (State or foreign country)

16. (a) Informant MRS OTTO HOLLAND
 (b) Address LONGLANE MO

17. (a) BURIAL (b) Date thereof 5-22-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DAIR LAWN18. (a) Signature of funeral director L.B. JONES(b) Address BUFFALO MO

19. (a) 7-2-47 (b) Grace Petter
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DALLAS
 (c) City or town LONGLANE RURAL
 (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 20
 year _____ hour 1 minute 0 A. M.

21. I hereby certify that I attended the deceased from Jan 47 to May 20 47
 that I last saw him alive on before May 19 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Embolism sudden
 Duration _____

Due to Influenza +
Arthritis

Due to Broken Hip

Other conditions None
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations None

Of autopsy None

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

(c) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence 30

(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 0

23. Signature Glenn Plummer (M. D. or other) MD
 Address Buffalo Mo Date signed 5-2-47

RECEIVED
District Health Officer No. 7,
District File Number 6-47-786
Date Filed 7-2-47

5 000

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 Morris B. Jones
Licensed Embalmer No. 4322
P. O. Address Buffalo NY

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.

Registration District No. 96

Primary Registration District No. 0356

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Rural
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Martin V. Caughman

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 _____

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

7. Birth date of deceased Sept 18 1888
(Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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) _____ (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 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him _____ alive on _____
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) 1867

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) accident

(b) Date of occurrence Dec. 31 1946

(c) Where did injury occur? Fell on ice & fractured hip
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, or public place?
Farm, out rounding up sheep
While at work? Yes (Specify type of place) Means of injury Fall

23. Signature Hub Plummer M.D. (M. D. or other) M.D.

Address Buffalo Mo Date signed _____

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

SUPPLEMENTARY

5-20443