V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 18 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21476

Registration District No. 170 Primary Registration District No. 3033 Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 411 S JEFFERSON 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 ALWAYS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County LACLEDE 53
(c) City or town LEBANON 1
(If outside city or town limits, write "RURAL")
(d) Street No. 411 S. JEFFERSON 2
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME MIRANDY TRUELOVE

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

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife JOHN TRUELOVE 6. (c) Age of husband or wife if alive years

7. Birth date of deceased MAY (Month) 22 (Day) 1877 (Year)

8. AGE: Years 77 Months — Days 12 If less than one day hr. min.

9. Birthplace LACLEDE Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name ALBERT BIGGS
13. Birthplace LACLEDE Co (City, town, or county) Mo (State or foreign country) 0

MOTHER
14. Maiden name MARGARET CAFFEY
15. Birthplace LACLEDE Co (City, town, or county) Mo (State or foreign country) 0

16. (a) Informant Mrs W. L. Murphy
(b) Address LEBANON Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-6-47 (Month) (Day) (Year)
(c) Place: burial or cremation LONESOME HILL CEM.

18. (a) Signature of funeral director PALMERS
(b) Address LEBANON Mo

19. (a) June 14 1947 (Date received local registrar) (b) Org Frankeberger 152 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4 year 1947 hour 4 minute AM.

21. I hereby certify that I attended the deceased from Feb, 1937 to 4 June, 1947 that I last saw her alive on 3 June, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart disease — Duration Yrs.

Due to Generalized arteriosclerosis

Due to and Senility.

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? (Specify type of place) 0
While at work (e) Means of injury

23. Signature Paul A Jenkins MD (M. D. or other)
Address Lebanon Mo. Date signed 6 June 47

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County .....

(b) City or town ..... (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 address or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

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)

Received 6/16/47

Laclede County Health Unit

File No. 6/47-104

Date Filed 6/17/47

3. (a) PRINT FULL NAME .....

4. (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** ..... years

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 .....

12. Name ..... } **EMBALMER**

13. Birthplace ..... (State or foreign country) } Registered Apprentice No.

14. Maiden name ..... } **FOLDER**

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

16. (a) Informant ..... Signed D. W. Palmer

(b) Address .....

17. (a) ..... (Burial, cremation, or removal) **(b) Date interred** ..... (Month) (Day) (Year)

(c) Place burial, cremation, or removal .....

(d) Address .....

18. (a) ..... (Date received local registrar) **(b)** ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year 2 ..... hour ..... minute ..... M.

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

Immediate cause of death ..... Duration

Due to .....

Due to .....

Other conditions ..... (Contributing causes within 3 months of death)

Major findings: .....

Operation ..... Date .....

PHYSICIAN Underline the cause to which death should be charged as.

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 ..... working under my personal supervision.

Licensed Embalmer No. 1161

P. O. Address Lebanon, Mo.

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? .....

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.

23. Signature ..... (M. D. or coroner) Address ..... Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

WHITE PAPER—USE INDIANA BLACK INK—MAKE A LEGIBLE RECORD