

FILED JUL 22 1947

Registration District No. **22**

Primary Registration District No. **58084342**

Registrar's No. **11**

1. PLACE OF DEATH:

(a) County Montgomery  
 (b) City or town Jonesburg  
 (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 40 yrs  
 years, months or days

3. (a) PRINT FULL NAME

Emma B. Lavender

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

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced divorced  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Month) (Day) (Year) 1872

8. AGE: Years Months Days If less than one day  
74 5 12 hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Mo

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Charles W. Lavender  
 13. Birthplace Cole County Mo  
 (City, town, or county) \_\_\_\_\_ (State or foreign country)  
 14. Maiden name Nancy Dodge  
 15. Birthplace Mo  
 (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Walter Barlow  
 (b) Address 311 West High Main St Pa

17. (a) Burial (b) Date thereof 6 15 47  
 (Burial, cremation, or removal) \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation Jonesburg Mo

18. (a) Signature of funeral director W.A. Harding

(b) Address Jonesburg Mo

19. (a) June 22 1947 (b) Miss May Miller  
 Date received local registrar's (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Montgomery  
 (c) City or town Jonesburg  
 (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 June day 12  
 year \_\_\_\_\_ hour 4 minute 25 P. M.

21. I hereby certify that I attended the deceased from June 4  
 1947, to June 12, 1947

that I last saw her alive on June 12, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration \_\_\_\_\_

Due to Hemorrhage of Stomach  
 Due to Stomach

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations X6 B

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) \_\_\_\_\_ (a) \_\_\_\_\_ (b) \_\_\_\_\_ (c) \_\_\_\_\_ (d) \_\_\_\_\_

23. Signature Chas. H. Anderson (M. D. or other) MO

Address Jonesburg Mo Date signed 6/14/47

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

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed JUN 30 1947

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: *Leal A. Daiding*

Licensed Embalmer No. *4115*

P. O. Address *Jonesburg Mo*

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. July  
Registrar's No. 118

Registration District No. 228

Primary Registration District No. 4342

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

1. PLACE OF DEATH:

(a) County Montgomery  
(b) City or town Jonesburg  
(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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME

Emma B. Lavender

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month July year 1947 day \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Dec 31 (Month) (Day) (Year)

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 \_\_\_\_\_

8. AGE: Years 74 Months 5 Days \_\_\_\_\_ (If less than one day) hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_ (Include pregnancy within 8 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 \_\_\_\_\_

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)

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-21704