

FILED JUL 20 1948

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22391**

Registration District No. **389**

Primary Registration District No. **5765**

Registrar's No. **17**

1. PLACE OF DEATH:

(a) County **Callaway**  
(b) City or town **Guthrie**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **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 **Life** years, months or days

3. (a) PRINT FULL NAME **Ruth Mandy Lucas**

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

4. Sex **Female** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Ben Lucas** 6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **Nov 19 1898** (Month) (Day) (Year)

8. AGE: Years **53** Months **8** Days **1** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Lebbeth** (City, town, or county) **MO** (State or foreign country)

10. Usual occupation **Housewife**

MOTHER FATHER 11. Industry or business

12. Name **Sant Ferguson**

13. Birthplace **unknown** (City, town, or county) **MO** (State or foreign country)

14. Maiden name **Lonia Morgan**

15. Birthplace **New Bloomfield** (City, town, or county) **MO** (State or foreign country)

16. (a) Informant **Dr. Compton**

(b) Address **208 E. 4th St. Jeff. Co. Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **July 22 1948** (Month) (Day) (Year)

(c) Place: burial or cremation **Oakley Cemetery**

18. (a) Signature of funeral director **Stacy Clayton**

(b) Address **New Bloomfield MO**

19. (a) **July 20 48** (b) **Stacy Clayton** (Registrar's signature) **29** (To be received by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Callaway**  
(c) City or town **Guthrie** (If outside city or town limits, write "RURAL") **17**  
(d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
(e) Citizen of foreign country? **no** (Yes or No) **0**  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **20** year **1948** hour **5** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **July 19** 19**48** to **July 20** 19**48** that I last saw her alive on **July 19** 19**48** and that death occurred on the date and hour stated above.

Immediate cause of death **Valvular Heart Disease** Duration \_\_\_\_\_

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

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

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

Major findings: Of operations **42 R**

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 **P. M. Rust** (M. D. or other) **0**  
Address **New Bloomfield MO** Date signed **7/20 1948**

VS SEP 22 1959

876102

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..... *LeRoy Clayton* .....

Licensed Embalmer No. *4412*

P. O. Address. *New Bloomfield*

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.