

No. 2  
5-43  
-17-19  
X38671

FILED NOV 5 1948

Registration District No. **1**

Primary Registration District No. **6117h**

1. PLACE OF DEATH:

(a) County **SCOTT**

(b) City or town **KELSO**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **HOME**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **24 YEARS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **SCOTT/MO.**

(c) City or town **KELSO.**  
(If outside city or town limits, write "RURAL")

(d) Street No. **✓** (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **✓**

3. (a) PRINT FULL NAME **IRVIN A. LEDURE**

3. (b) If veteran, name war: \_\_\_\_\_ 3. (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 **IRIS** 6. (c) Age of husband or wife if alive **13 - 1923** years (Month) (Day) (Year)

7. Birth date of deceased **JAN. 13 - 1923** (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCT.** day **24** year **1948** hour **12** minute **30 A.M.**

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

8. AGE:

Years	Months	Days	If less than one day
<b>25</b>	<b>9</b>	<b>11</b>	hr. _____ min. _____

Immediate cause of death **1st, 2nd + 3rd, DEGREE BURNS**

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

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

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

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

10. Usual occupation **Farmer**

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

12. Name **BEN LEDURE**

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

14. Maiden name **OLIVIA SCHERER**

15. Birthplace **SCOTT, Co. MO.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. IRIS LEDURE**

(b) Address **KELSO. MO.**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **OCT 26 - 48** (Month) (Day) (Year)

(c) Place: burial or cremation **KELSO. MO.**

18. (a) Signature of funeral director **Walthus Funeral Home**

(b) Address **Loane Girardeau Mo**

19. (a) **10-2-48** (Date received local registrar) (b) **S. J. D...** (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) **ACCIDENT**

(b) Date of occurrence **24 OCTOBER 1948**

(c) Where did injury occur? **KELSO. Scott MO**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**HOME FIRE** (Specify type of place)

While at work? \_\_\_\_\_ (c) Means of injury **BURNS**

23. Signature **Orville Taylor Coover**

Address **Suburban, Mo** Date signed **10/24/48**

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

RECEIVED

District Health Office No. 2,

District File Number 1048-1393

Date Filed 10-30-48

MAY 8  
1959

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 William Lee Jones

Licensed Embalmer No. 4410

P. O. Address Cape Girardeau, 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. no  
Registrar's No. 24

Registration District No. 330

Primary Registration District No. 61121

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Keosauqua  
(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 Irina Ledene

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

4. Sex m 5. Color of race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Jan 13  
(Month) (Day) (Year)

8. AGE: Years 25 Months 9 Days 17 (If less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) NO

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 \_\_\_\_\_ Year \_\_\_\_\_ Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. (Immediate cause of death)

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFRACTIONATED

S-35309