No. 2
4-13-40
5-17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 20 1948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39792

Registration District No. 112 — Primary Registration District No. 5428 — Registrar's No. 26

1. PLACE OF DEATH:
(a) County FRANKLIN
(b) City or town ~~SULLIVAN~~ Leslie Rural. Boone
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin 36
(c) City or town Leslie ~~Sullivan~~ Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R7 A2
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME IDA LAUBINGER
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August 15, 1870 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	78	2	24	hr. min.

9. Birthplace Franklin Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Home

FATHER
12. Name William Harris
13. Birthplace (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Cooper
15. Birthplace (City, town, or county) Missouri (State or foreign country)

16. (a) Informant John Laubinger
(b) Address Leslie ~~Sullivan~~, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, '48 (Month) (Day) (Year)
(c) Place: burial or cremation Cave Spring Cemetery
18. (a) Signature of funeral director Thos. P. Shoffer
(b) Address Sullivan, Missouri
19. (a) 11-1-48 (Date received local registrar) (b) G L Matthews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29
year 1948 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from Nov 28, 1947 to Oct 29, 1948
that I last saw her alive on Aug 15, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Apoplexy	1 da
Due to General Arteriosclerosis	
Due to	
Other conditions Chronic Varicose Ulcers (Include pregnancy within 3 months of death)	

Major findings:
Of operations No operation
Of autopsy No 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)
While at work? (e) Means of injury

23. Signature G L Matthews MD (M.D. or other)
Address Beaufort Mo Date signed 11-1-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number 12-17-48
Date Filed

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 Edgar W Calloway

Licensed Embalmer No. 23394

P. O. Address Sullivan Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.