

FILED SEP 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30907**

BIRTH NO. _____		REG. DIST. NO. 171		PRIMARY REG. DIST. NO. 4267		Registrar's No. 17		
1. PLACE OF DEATH a. COUNTY Lafayette Odessa				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lafayette				
b. CITY OR TOWN Rural Washington Twms.		c. LENGTH OF STAY (in this place) 50 Yrs		c. CITY OR TOWN Rural Washington Twms.		50		
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) 4 Mi. East of Odessa				
3. NAME OF DECEASED a. (First) Thomas			b. (Middle) N.		c. (Last) Lale		4. DATE OF DEATH (Month) (Day) (Year) Aug 19, 1949	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Mar. 23, 1867		9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen Farming		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME William Lale			13b. MOTHER'S MAIDEN NAME Mary Jane Hutchison		14. NAME OF HUSBAND OR WIFE Nellie Lale			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Nellie Lale ADDRESS Odessa, Mo.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paralysis of Rt. side of tongue due to unknown causes				INTERVAL BETWEEN ONSET AND DEATH
				ANTECEDENT CAUSES DUE TO (b) Malnutrition				
				DUE TO (c) Senility				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				3.52X				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from Aug 10, 1949 , to Sep 19, 1949 , that I last saw the deceased alive on 8/18, 1949 , and that death occurred at 2:50 p.m. , from the causes and on the date stated above.								
23a. SIGNATURE (Deputy or title) W. H. H. H.				23b. ADDRESS Odessa, Mo.		23c. DATE SIGNED 9/24/49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 21, 1949	24c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery		24d. LOCATION (City, town, or county) (State) Odessa, Mo.			
DATE REC'D BY LOCAL REG. 8/21/49		REGISTRAR'S SIGNATURE Lella H. H. H.		25. FUNERAL DIRECTOR'S SIGNATURE Hushman Sparks		ADDRESS Odessa, Mo.		

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

RECEIVED SEP 2
District Health Officer No. 8,
District File Number _____
Date Filed 9-16-19

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed William T. Spa

Licensed Embalmer No. # 4431

P. O. Address Odessa, Fla.

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.