No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41619

FILED JAN 6 1950

BIRTH NO. _____ REG. DIST. NO. 181 PRIMARY REG. DIST. NO. 5675 Registrar's No. 28

1. PLACE OF DEATH
a. COUNTY: Lincoln
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural (Hurricane)
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Missouri
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural (Hurricane) 57
d. STREET ADDRESS (If rural, give location): Near Elsberry, Mo

3. NAME OF DECEASED (Type or Print)
a. (First): JUDA
b. (Middle): BELLE
c. (Last): LAIRD

4. DATE OF DEATH (Month) (Day) (Year): NOV 29, 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Oct 24 1898
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months 1 Days 5 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Perry Slaughter
13b. MOTHER'S MAIDEN NAME: Lillie Miller
14. NAME OF HUSBAND OR WIFE: Henry Laird

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Henry Laird ADDRESS: Elsberry, 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PNEUMONIA ATYPICAL — INTERVAL BETWEEN ONSET AND DEATH: 2 WKS

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) BRONCHIECTASIS — 3 YRS
DUE TO (c) CHR BRONCHITIS — 3 YRS +

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* INSIPIENT TUBERCULOSIS — 3 YRS +

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

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): Ky
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* NOV 28, 1949, *to* NOV 28, 1949, *that I last saw the deceased alive on* NOV 28, 1949, *and that death occurred at* 2:4 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature]
(Degree or title): M.D.
23b. ADDRESS: ELSBERRY, MO
23c. DATE SIGNED: 11/29/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/2/49
24c. NAME OF CEMETERY OR CREMATORY: Elsberry Cem.
24d. LOCATION (City, town, or county) (State): Elsberry Mo

DATE REC'D BY LOCAL REG.: 12/30/49
REGISTRAR'S SIGNATURE: Mrs. J. L. Durley 164
25. FUNERAL DIRECTOR'S SIGNATURE: Clifton Miller ADDRESS: Elsberry

(Licensed/Embalmer's Statement on Reverse Side)

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

RECEIVED JAN 3 1950
District Health Officer No. 9,
District File Number.....

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~~ 11/29/9

....., Student Embalmer No. .....

working under my personal supervision.

Signed Clifton Miller

Licensed Embalmer No. 3364

P. O. Address Elsworth, Me.

Signed.....
Student Embalmer

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.