

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHDr. Schulte
21891
State File No. _____

FILED JUN 30 1953

BIRTH NO. _____		REG. DIST. NO. <u>156</u>		PRIMARY REG. DIST. NO. <u>2001</u>		Registrar's No. <u>292</u>			
1. PLACE OF DEATH a. COUNTY <u>Lasher</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>mo</u>				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Joplin</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - west of Joplin</u>		d. STREET ADDRESS (If rural, give location) <u>Carl Junction RFD #1</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Stephens Hospital</u>				3. NAME OF DECEASED a. (First) <u>Joe</u>				b. (Middle) <u>Leonard</u>	
c. (Last) <u>Larson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6-15-53</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Aug 2-1892</u>			
9. AGE (In years last birthday) <u>60</u>		# UNDER 1 YEAR Months _____ Days _____		# UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work and duration of working hours, except if retired) <u>Miller's</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Natl Gypsum Co</u>			11. BIRTHPLACE (State or foreign country) <u>Hoinet mo</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Lola Belle Larson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, list in (16)) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>445-01-9503</u>		17. INFORMANT'S SIGNATURE OR NAME <u>ma Lola Belle Larson</u>			ADDRESS <u>Joplin</u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>2</u>					
				DUE TO (c) _____					
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331XG</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>cerebral hemorrhage Edema Lung and Pneumonitis</u>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>6-15-53</u> , and that death occurred at <u>7:40 P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>R. L. Ferguson M.D.</u>				23b. ADDRESS <u>821 Frisco Bldg.</u>		23c. DATE SIGNED <u>June 17, 1953</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>6-15-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Baylor Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Baylor Spgs Mo</u>			
DATE REC'D BY LOCAL REG. <u>6-18-53</u>		REGISTRAR'S SIGNATURE <u>Ed S. James</u>			25. FUNERAL DIRECTOR'S SIGNATURE (Address) <u>James Wene</u> <u>Baylor Spgs Mo</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 6-29-53
Jasper County Health
County File Number 53-6-
Date Filed 6-29-53

1953

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 _____

Wene Funeral Home

Student Embalmer No. _____

working under my personal supervision.

Student *Roy Perfelt*
Student Embalmer

Signed *J Lane Wene*
Licensed Embalmer No. *2880 mo¹*

P. O. Address *Box 1048 Hans*

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.