

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

THE DIVISION OF HEALTH OF MASSACHUSETTS
STANDARD CERTIFICATE OF DEATH

State File No. **25473**

FILED JUL 23 1953

BIRTH NO. **44517-53** REG. DIST. NO. **170** PRIMARY REG. DIST. NO. **3033** Registrar's No. **108**

1. PLACE OF DEATH a. COUNTY Lachedle		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Ma b. COUNTY Lachedle	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lebanon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lebanon	
c. LENGTH OF STAY (in this place) 3 hrs.		d. STREET ADDRESS (If rural, give location) 356 Van Buren	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION WALLACE HOSPITAL			

3. NAME OF DECEASED a. (First) TONY b. (Middle) LAVON c. (Last) Southard			4. DATE OF DEATH (Month) (Day) (Year) July 12 1953			
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH JULY 12 1953	9. AGE (in years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 100 Hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lebanon Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Herbert Southard		13b. MOTHER'S MAIDEN NAME Maxine Reeves		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Miss Herbert Southard ADDRESS Lebanon 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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth		INTERVAL BETWEEN ONSET AND DEATH 1 hr.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 5-months pregnancy		
	DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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)		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 **7-12, 1953** to **7-12, 1953** that I last saw the deceased alive on **7-12, 1953** and that death occurred at **4:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE B.B. (first) M.D. (Degree or title)		23b. ADDRESS Lebanon, Mo.		23c. DATE SIGNED 7-13-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 7/13/53		24c. NAME OF CEMETERY OR CREMATORY Graceland		24d. LOCATION (City, town, or county) (State) CONWAY Mo	
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DATE REC'D BY LOCAL REG. 7-14-1953		REGISTRAR'S SIGNATURE Hella L. May		25. FUNERAL DIRECTOR'S SIGNATURE Palmer ADDRESS Lebanon Mo.	
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JUL 18 1953

Received

Laclede County Health Unit

File No. 7-82-114

Date Filed JUL 21 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

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *NAT Embalmed*

Licensed Embalmer No.

P. O. Address

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

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