

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 366 Primary Registration District No. 6246 Registrar's No. 81 STATE FILE NUMBER 63-042558

<b>FILED NOV 13 1963</b>	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Concord</u> Length of stay in 1b <u>26 yrs.</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN <u>Irondale</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Rural</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Percy Herman LaBudde</u>	<b>4. DATE OF DEATH</b> Month Day Year <u>Nov. 6, 1963</u>
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>
<b>8. DATE OF BIRTH</b> <u>6-29-1893</u> <b>9. AGE</b> (last birthday) <u>70</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>St. Joseph Lead Co.</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Garner, Iowa</u>
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	<b>13a. FATHER'S NAME</b> <u>Paul LaBudde</u>
<b>13b. MOTHER'S MAIDEN NAME</b> <u>Ida Yeigh</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mable LaBudde</u>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> Address <u>Mable LaBudde, Irondale RR, Mo.</u>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> DUE TO (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
<b>21. I attended the deceased from</b> <u>Aug 63</u> to <u>Nov 63</u> and last saw him alive on <u>Nov 5/63</u> Death occurred at <u>5-AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
<b>22a. SIGNATURE</b> (Degree or title) <u>[Signature]</u>	<b>22b. ADDRESS</b> <u>Burns, Mo</u>
<b>22c. DATE SIGNED</b> <u>11/9/63</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>Nov. 8-1963</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hopewell Cemetery</u> <b>23d. LOCATION</b> (City, town, or county) (State) <u>Mineral Point R1, Mo.</u>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Bert L. Boyer, Leadwood, Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>11-12-63</u> <b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 22 1963

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Ben H. Bayer*

Licensed Embalmer No. 13445

P. O. Address Leadwood Mo

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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