

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

36654

1. PLACE OF DEATH

County..... *Henry*
Township..... *Clinton*
City..... *Henrietta* (No.)

Registration District No. *347*
Primary Registration District No. *5488*

File No.
Registered No. *129*
St. Ward)

2. FULL NAME..... *Miss Daisy Lucas*

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7* | 4. COLOR OR RACE *white* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Walter Lucas*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 4 - 1888*

7. AGE YEARS MONTHS DAYS | IF LESS than 1 day, hrs. or min.
39 | *X* | *20*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... *House work*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... *Clinton mo*
(STATE OR COUNTRY)..... *Henry Co*

10. NAME OF FATHER..... *John B Hammond*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... *Ohio*
(STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER..... *Ada Hause*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... *Illinois*
(STATE OR COUNTRY).....

14. INFORMANT..... *Lee Hammond*
(Address)..... *Clinton mo*

15. FILED..... *Dec 29 1927* Dr. E. C. Peeler
REGISTRAR
Harris by J.F.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 24th 1927*

17. I HEREBY CERTIFY, That I attended deceased from *June 10th 1927*, to *Dec 24th 1927*, that I last saw her alive on *Dec 24th 1927*, and that death occurred, on the date stated above, at *8 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer Sup. Maxillary Bone
530
43
(duration) yrs. *9* mos. ds.

CONTRIBUTOR (SECONDARY).....
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... *No* DATE OF.....
20. WAS THERE AN AUTOPSY?..... *No*
WHAT TEST CONFIRMED DIAGNOSIS?..... *microscopical*
(Signed)..... *Robt. D. Haire, M. D.*
....., 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... *Eglewood Cemetery* DATE OF BURIAL..... *Dec 25 1927*

20. UNDERTAKER..... *Spore & Son* ADDRESS..... *Clinton mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 1 1928

PARENTS

