

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 27 1947

Registration District No. 99

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 0376

34096

State File No. _____

Registrar's No. 40

1. PLACE OF DEATH:

(a) County De Kalb
(b) City or town Rural Henderson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1/2 mile north of Cameron Highway #69
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6
(Specify whether
In this community 78 yrs.
years, months or days)

3. (a) PRINT

FULL NAME LAURETTA ANN MIDDAGH

8. (b) If veteran,

name war ✓

3. (c) Social Security

No. ✓

4. Sex Female / 5. Color or race W
6. (b) Name of husband or wife Ben Middagh
6. (c) Age of husband or wife if alive 27 years
7. Birth date of deceased Nov 18 1853
(Month) (Day) (Year)

8. AGE: Years 93 Months 9 Days 29
If less than one day hr. min.

9. Birthplace Clark Co Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

MOTHER FATHER { 12. Name William H Stafford
13. Birthplace no record Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Mary E Baugh
15. Birthplace no record Va
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Vern Henderson
(b) Address Cameron

17. (a) Burial (b) Date thereof 9-28-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mc Daniel cem.

18. (a) Signature of funeral director Robert Emanuel Stone

(b) Address Jefferson

19. (a) 9-31-47 (b) R. L. Anderson
(Date received local registrar) (Registrar's signature) 821

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County De Kalb 32
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 1/2 mi. north of Cameron Highway #69 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1947 hour _____ minute 600 AM

21. I hereby certify that I attended the deceased from Sept 1 1947 to Sept 25 1947
that I last saw him alive on Sept 25 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Dehydration + electrolyte imbalance
Due to intestinal obstruction 10 days
Due to man in abdomen 15

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 122 B

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) (e) Means of injury 0

23. Signature R. L. Anderson (M. D. or other) 0
Address Cameron Mo Date signed _____

Sept 26 47

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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, above space should be left blank.