Do not use this space.

20808

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

1. PLACE OF DEATH
County. Laclede — Registration District No. 448 — File No. 186
Township. Hazelgreen — Primary Registration District No. 5608 — Registered No. 156
City. Conway — St. — Ward)

2. FULL NAME Rebecca J Adams

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

5A. If Married, Widowed, or Divorced
HUSBAND of (or) WIFE of F. M. Adams

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 2 - 1844

7. AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	80	2	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Pebbstake Co Mo.

PARENTS

10. NAME OF FATHER W M Hawes
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER D - - -
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Virginia

14. INFORMANT W. J. Adams
(Address) Shallowford

15. FILED Aug 7 1924 N. B. Clinton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19th 1924

17. I HEREBY CERTIFY, That I attended deceased from Oct 23rd, 1923, to Oct 24th, 1923, that I last saw h[illegible] alive on Oct 28th, 1923, and that death occurred, on the date stated above, at 4:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cause of death unknown, living only seven days after onset

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) old age

(duration) yrs. mos. ds.

164

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) R. A. Stewart, M. D
, 19 (Address) Phillipsburg Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New Hope	July 20 1924
20. UNDERTAKER N B Clinton	ADDRESS Conway

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.

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 8 1957

42005 STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 205

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lebanon — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Knox Rest Home — Length of stay in lb 244 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Laclede
c. CITY OR TOWN Lebanon — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) Oakland Route — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Lizzie Middle Belle Last Bacon
4. DATE OF DEATH: Month Dec. Day 28. Year 1956
5. SEX: F
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 27. 1874
9. AGE (In years last birthday): 82
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Laclede Co. Mo
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: A. G. Galloway
14. MOTHER'S MAIDEN NAME: Edna Nancy Bud
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mrs. Eunice Speaker Lebanon Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency — Interval between onset and death: Minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — Interval between onset and death: Indef
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 4200
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE: Linn

21. I attended the deceased from January 7, 1955 to December 28, 1956 and last saw her/him alive on Sept 13, 1956
Death occurred at 12-28-56 8:10 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Paul A Jenkins MD
22b. ADDRESS: Knight Bldg. Lebanon Mo
22c. DATE SIGNED: 12/31/56

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12/31/56
23c. NAME OF CEMETERY OR CREMATORY: New Hope Cemetery
23d. LOCATION (City, town, or county) (State): near Russ Mo.

24. FUNERAL DIRECTOR ADDRESS: Holman, Lebanon, Mo.
25. DATE RECD. BY LOCAL REG.: 12-31-1956
26. REGISTRAR'S SIGNATURE: Wella L. Hay

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 24 1947

Registration District No. 5632

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13970

Primary Registration District No. 5632

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Oakland (Rural)
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Entire life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas Malcom Bacon
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male | 5. Color or race W | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lizzie Bacon
6. (c) Age of husband or wife if alive 73 years

7. Birthdate of deceased Jan. (Month) 10 (Day) 1872 (Year)

8. AGE: Years 75 | Months 3 | Days — | If less than one day ____ hr. ____ min.

9. Birthplace Laclede Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business Farm
MOTHER FATHER
12. Name Daniel D. Bacon
13. Birthplace Vermont (City, town, or county) (State or foreign country)
14. Maiden name Mary Kemp
15. Birthplace Scotland (City, town, or county) (State or foreign country)
16. (a) Informant Ivan Bacon (Son)
(b) Address Lebanon, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-47 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope Cemetery
18. (a) Signature of funeral director W. E. Holsman
(b) Address Lebanon Mo.
19. (a) April 19, 1947 (Date received local registrar) Ora Frankenberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10th year 1947 hour 5 minute ____ A. M.

21. I hereby certify that I attended the deceased from April 1, 1947 to April 10, 1947 that I last saw h. alive on April 10, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Apoplexy	
Due to: Cerebral Hemorrage	
Due to	
Other conditions (Includes pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

§ 3 A

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

23. Signature W. F. Schuick (M. D. or other)
Address Niangua Mo Date signed 4/4/47

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11131

FILED APR 21 1941

Registration District No. 449 — Primary Registration District No. 4267 — Registrar's No.

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.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town LEBANON (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ASEMBLY OF GOD CHURCH (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ALWAYS 12

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County LACLEDE
(c) City or town LEBANON (If outside city or town limits, write "RURAL") 5 3 0 0
(d) Street No. R 5 (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME MARY WILSON
3. (b) If veteran, name war ____
3. (c) Social Security No. None

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife JASPER WILSON
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased NOT KNOWN (Month) (Day) (Year)

8. AGE: Years 59 | Months — | Days — | If less than one day ____ hr. ____ min.

9. Birthplace LACLEDE Co (City, town, or county) MO (State or foreign country)
10. Usual occupation HOUSE KEEPER
11. Industry or business ____
FATHER 12. Name J.W. ADAMS
13. Birthplace LACLEDE Co (City, town, or county) MO (State or foreign country)
MOTHER 14. Maiden name ANNA CASEY
15. Birthplace LACLEDE Co (City, town, or county) MO (State or foreign country)
16. (a) Informant's own signature J. A. Chastain
(b) Address LEBANON MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 18 1941 (Month) (Day) (Year)
(c) Place: burial or cremation NEW HOPE CEM
18. (a) Signature of funeral director PALMER'S 464
(b) Address LEBANON MO
19. (a) 4-17-41 (Date received local registrar) (b) J A McCord (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 16
year 1941 hour 12 minute 15 P M.
21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__;
that I last saw h. ____ alive on ____, 19__;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Thrombosis of Heart	X
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature James E Stanton (Coroner) (Er. Practitioner)
Address ____ Date signed 3-17-41

(Licensed Embalmer's Statement on Reverse Side)

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.

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

26537

PLACE OF DEATH

County Laclede

Township Lebanon or Village or City

Registration District No. 449 File No.

Primary Registration District No. 5604 Registered No.

(No. Near Eamus St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ernest Noel Bruce

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF DATE Nov 21, 1913 (Month) (Day) (Year)

AGE 9 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 1914

BIRTHPLACE (City or town, State or foreign country) Laclede Co Mo

PARENTS

NAME OF FATHER Chas B Bruce

BIRTHPLACE OF FATHER (City or town, State or foreign country) Laclede Co Mo

MAIDEN NAME OF MOTHER Emma Simmons

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Laclede Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Bruce

(ADDRESS) Lebanon

Filed Aug 27 1914 J H Bellamy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 22, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 19, 1914, to Aug 22, 1914, that I last saw him alive on Aug 21, 1914, and that death occurred, on the date stated above, at 9 00 m.

The CAUSE OF DEATH* was as follows:

Surgical Fever

of Watermelon seed becoming

Lodged in windpipe.

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

8/22 1914 (Address) Lebanon Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Hope	Aug 23 1914
UNDERTAKER	**ADDRESS**
R A Polumus	Lebanon

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

Do not use this space.

19883

JUN 22 1936

1. PLACE OF DEATH
County Laclede — Registration District No. 449
Township ... — Primary Registration District No. 4267
City Lebanon (No. ... St. ... Ward)

File No. ...
Registered No. ...

2. FULL NAME Elmer Barker

(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: M | 4. COLOR OR RACE: W | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: Mary Wallace

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): ~~Sept 4 1877~~

7. AGE — YEARS: 58 | MONTHS: 8 | DAYS: 27 | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Retired Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: ...

10. Date deceased last worked at this occupation (month and year): ... 11. Total time (years) spent in this occupation: ...

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Laclede Co Mo

FATHER

13. NAME: J. C. Barker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ky

MOTHER

15. MAIDEN NAME: Nancy Tuffett

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ky

17. INFORMANT (ADDRESS): Mrs. Mary Wallace Lebanon

18. BURIAL, CREMATION, OR REMOVAL
PLACE New Hope DATE May 30 1936

19. UNDERTAKER (ADDRESS): Pobmeyer Lebanon

20. FILED 6-1-1936 J. A. McBride Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 28 1936

22. I HEREBY CERTIFY, That I attended deceased from May 14, 1936, to May 28, 1936
I last saw him alive on May 25, 1936. Death is said to have occurred on the date stated above, at 2:30 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Shock, following a prostatectomy 1937	1932

Other contributory causes of importance:
Hypostatic pneumonia of the left lobe
Super-pubic drainage — 3/14/36
Name of operation? Prostatectomy Date of? 3/27/36
What test confirmed diagnosis? Physical examination Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ...
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
...
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify ...
(Signed) P. Thompson M.D., M. D.
(Address) Lebanon 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.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County Laclede. Registration District No. 449 File No. 33291

Township Lebanon. Primary Registration District No. 5609 Registered No. 174

or Village ____

or City ____ (No. ____ St. ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William Harley Breech

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	White	single

DATE OF BIRTH: ~~Oct~~ June 28, 1908 (Month) (Day) (Year)

AGE: 4 yrs. 3 mos. 16 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Laclede co mo

PARENTS

NAME OF FATHER: Chas - Breech

BIRTHPLACE OF FATHER (City or town, State or foreign country): Laclede Co. Mo

MAIDEN NAME OF MOTHER: Annie Tennison

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Laclede Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William H Breech

(ADDRESS) Lebanon

Filed Oct-15 1912 J. M. Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct. 14, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 12, 1912, to Oct 15, 1912, that I last saw him alive on Oct 15, 1912, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheritic
ID Membranous
Croup

(Duration) ___ yrs. ___ mos. 5 ds.

Contributory (Secondary) ____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) S. A. Casey M. D.

10/16 1912 (Address) Lebanon Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hutchins	Oct 16 1912
UNDERTAKER	**ADDRESS**
Russ Eikmeier	Lebanon

S. No. 2
M—1-4-41
V. 5-17-39
X25390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 30 1942

Registration District No. 4448 4-1

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2656

Primary Registration District No. 4267

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town LEBANON TWP
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
723 N MONROE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community ALWAYS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE

(c) City or town LEBANON
(If outside city or town limits, write "RURAL")

(d) Street No. 723 N MONROE
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME HENRIETTA D CAMPBELL

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, or divorced MARRIED

6. (b) Name of husband or wife LAWRENCE CAMPBELL

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased FEB (Month) 26 (Day) 1901 (Year)

8. AGE: Years	Months	Days	If less than one day
39	10	6	hr. min.

9. Birthplace LACLEDE Co (City, town, or county) MO (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business

MOTHER FATHER

12. Name HENRY DAVIS

13. Birthplace LACLEDE Co (City, town, or county) MO (State or foreign country)

14. Maiden name BELL BARKER

15. Birthplace LACLEDE Co (City, town, or county) OMO (State or foreign country)

16. (a) Informant Lawrence Campbell

(b) Address LEBANON MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 4 42 (Month) (Day) (Year)

(c) Place: burial or cremation NEW HOPE CEM.

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) Jan. 5 1942 (Date received local registrar) (b) Grace Rogers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 2
year 1942 hour 9 minute 40 P M.

21. I hereby certify that I attended the deceased from Dec 5 1941, 19 41, to JAN 2, 19 42
that I last saw HER alive on JAN 2, 19 42
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Ulcerative Colitis	
CARDIAC decompensation	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 1206

Of autopsy None

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature O L Bohon (M. D. or other) D.O.

Address LEBANON MO Date signed 1/2/42

1070

(Licensed Embalmer's Statement on Reverse Side)

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

1858

1. PLACE OF DEATH
County Laclede Registration District No. 2449 File No.
Township Primary Registration District No. 4267 Registered No. 720
City Lebanon (No. St. Ward)

2. FULL NAME John Cornelius Barker

(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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	white	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5 - 18 - 1835

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	8	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Doctor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bloomfield Ky.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Annaias Barker
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Brown.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT Elmer Barker
(Address) Lebanon. Mo.

15. FILED 1/19, 1920 J. M. Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 - 18 1920

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.. to ....., 19..
that I last saw h..... alive on ....., 19.., and that
death occurred, on the date stated above, at 6.00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis - Cerebral hemorrhage
8 d F
7 7 (duration) Instantaneous yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. A. McCoubs, M. D
, 19 (Address) Lebanon. Mo.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
White Oak Pond	Jan 20 1920
20. UNDERTAKER R A Palmer	ADDRESS Lebanon Mo.

S. No. 2
M—5-42
6-17-39
X32873

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

EPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1465

State File No.

Registration District No. 12 JAN 21 1943

Primary Registration District No. 3005

Registrar's No. 71

1. PLACE OF DEATH:
(a) County Bates
(b) City or town Butler
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 1 week.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Bates
(c) City or town Butler, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. S. Mechanic St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JAMES DANIEL BARR
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 30 (Day) 1865 (Year)

8. AGE: Years 76 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Lebanon (City, town, or county) Tenn (State or foreign country)
10. Usual occupation farmer
11. Industry or business
FATHER
12. Name Samuel Barr
13. Birthplace Fairfax Co (City, town or county) Ken (State or foreign country)
MOTHER
14. Maiden name Mary Whitson
15. Birthplace Nelson Co (City, town, or county) Tenn (State or foreign country)
16. (a) Informant D. W. Barr
(b) Address Butler Mo
17. (a) Cremated (Burial, cremation, or removal) (b) Date thereof Dec 7, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Lebanon, Mo
18. (a) Signature of funeral director Lenlees
(b) Address Butler Mo
19. (a) Dec 6, 1942 (Date received local registrar) (b) Mrs Marvine Cumpton (Registrar's signature)

1306

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. 6, 42 day
year 6 th hour 10 minute M.
21. I hereby certify that I attended the deceased from Dec. 1, 1942 to Dec. 6, 42
that I last saw him alive on Dec. 5, 42
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Nephritis	
with Uremia,	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
Of autopsy None	

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

23. Signature C. M. Rice M.D. (M. D. or other)
Address Butler Mo. Date signed Dec 6 42

S. No. 2
1—1-4-41
5-17-39
XZ6390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 21 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

WAshoA 14723
State File No.

Registration District No. 44449 Primary Registration District No. 5612 Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town WASHINGTON Twp.
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution: LEBANON PLATO STAR ROUTE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community ALWAYS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County LACLEDE
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. LEBANON, PLATO STAR ROUTE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert Milton Bolles
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M C
5. Color or race WH
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Lorendia Wilkerson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 30 (Day) 1868 (Year)

8. AGE: Years 74 Months Days 12 If less than one day hr. min.

9. Birthplace LACLEDE (City, town, or county) MO (State or foreign country)
10. Usual occupation FARMER
11. Industry or business

FATHER
12. Name Ewin Bolles
13. Birthplace Bolling Berg (City, town, or county) Ky (State or foreign country)

MOTHER
14. Maiden name Serena A. Towery
15. Birthplace Logan Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant Earnest Bolles
(b) Address LEBANON MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4 13 42 (Month) (Day) (Year)
(c) Place: burial or cremation NEW HOPE CEM
18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO
19. (a) 4-13-42 (Date received local registrar) (b) Grace Rogers (Registrar's signature)

1090 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 11
year 1942 hour 4 minute P. M.
21. I hereby certify that I attended the deceased from 4-8 19 42 to 4-11 19 42
that I last saw h[illegible] alive on 4-11 19 42
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	2-3 hrs
Due to Carcinoma Prostate	2 yrs
Due to Cystitis - Urolithiasis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 51 P
Of autopsy

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

23. Signature W. Bolles MD (M. D. [illegible])
Address Lebanon Mo Date signed 4/13/42

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

Do not use this space.

17248

1. PLACE OF DEATH
County Laclede — Registration District No. 449
Township ____ — Primary Registration District No. 4267
City Lebanon (No. ____, St. ____, Ward)

File No. ____
Registered No. ____

2. FULL NAME Mary Jane Carnett

(a) Residence. No. ____ St., ____ Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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.

JUN 23 1934

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: P B Carnett

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Nov. 20-1862

7. AGE — YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
71	6	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Green County Ark.

FATHER

13. NAME: Henry C Glover

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ark.

MOTHER

15. MAIDEN NAME: Mary Richey

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Tenn.

17. INFORMANT (ADDRESS): P. B. Carnett Lebanon

18. BURIAL, CREMATION, OR REMOVAL
PLACE New Hope DATE 5/24/34

19. UNDERTAKER (ADDRESS): Palmer Lebanon

20. FILED May 24 1934 J. A. McCord Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 22, 1934

22. I HEREBY CERTIFY, That I attended deceased from May 5 1934 to May 22 1934

I last saw h[er] alive on May 22 1934 Death is said to have occurred on the date stated above, at 5:15 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemmorhage	May 2
R.H.	
Other contributory causes of importance:	

Name of operation: None Date of:
What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury ____, 19____
Where did injury occur? ____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury: ____
Nature of injury: ____

24. Was disease or injury in any way related to occupation of deceased? ____
If so, specify ____

(Signed) P. Thompson M. D.
(Address) Lebanon Mo

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3119

Registration District No. 449 — Primary Registration District No. 4767 — Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town LEBANON (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 312 N Madison (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution / (Specify whether years, months or days) In this community OVER 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County LACLEDE
(c) City or town LEBANON (If outside city or town limits, write "RURAL")
(d) Street No. 312 N MADISON (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME REDMAN BOYD CARNETT
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MARY SHAVER
6. (c) Age of husband or wife if alive years
7. Birth date of deceased DEC (Month) 19 (Day) 1861 (Year)

8. AGE: Years 79 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace BATESVILLE (City, town, or county) ARK (State or foreign country)
10. Usual occupation RETIRED, BABTIST MINISTER
11. Industry or business

FATHER
12. Name WM CARNETT
13. Birthplace LEXINGTON (City, town, or country) KY (State or foreign country)

MOTHER
14. Maiden name SUSANA McCLASHEN
15. Birthplace CALICO ROCK (City, town, or country) ARK (State or foreign country)

16. (a) Informant's own signature J L Carnett
(b) Address Big Spring, Tenn
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 (Month) 14 (Day) (Year)
(c) Place: burial or cremation NEW HOPE CEMETARY
18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO
19. (a) 1-17-41 (Date received local registrar) (b) J A McCurdy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 13
year 1941 hour 12 minute 35 A M.
21. I hereby certify that I attended the deceased from 11-26 19 40 to January 13 19 41;
that I last saw him alive on January 13 19 41;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	
Due to Pneumonia and	
Due to Flu	
Other conditions (Include pregnancy within 3 months of death) 2 0	

Major findings:
Of operations
Of autopsy

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

23. Signature J L Carnett (M. D. or other)
Address Lebanon, Mo Date signed 1-24-41

(Licensed Embalmer's Statement on Reverse Side)

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.

No. 300
10-48

FILED MAY 16 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

17274 State File No.

BIRTH NO. 537 0 REG. DIST. NO. 180 PRIMARY REG. DIST. NO. 3033 Registrar's No. 279

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

1. PLACE OF DEATH
a. COUNTY: Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lebanon
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wallace Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Laclede
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lebanon 0532 0
d. STREET ADDRESS (If rural, give location): 203 Grand St.

3. NAME OF DECEASED (Type or Print): a. (First) Noah b. (Middle) Thomas c. (Last) Chastain

4. DATE OF DEATH: May 5, 1950

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 22, 1871

9. AGE (In years last birthday): 78 — If under 1 year: Months 8, Days 13 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Laclede Co. Mo

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: James Henry Chastain

13b. MOTHER'S MAIDEN NAME: Julia Renner

14. NAME OF HUSBAND OR WIFE: Sarah C. Chastain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS: James Chastain 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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Senility — Several years.

DUE TO (c): Hypertension

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

331X

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

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) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 4/6, 1950, *to* 5/4, 1950, *that I last saw the deceased alive on* 5/4, 1950, *and that death occurred at* 4:20 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ferrell H. Johnson MD

23b. ADDRESS: Lebanon Mo

23c. DATE SIGNED: 5/6/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: May 7, 1950

24c. NAME OF CEMETERY OR CREMATORY: New Hope Cemetery

24d. LOCATION (City, town, or county) (State): Laclede Co. Mo. Near Russ

DATE REC'D BY LOCAL REG.: 5-7-1950

REGISTRAR'S SIGNATURE: Hella L. May 4624

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. E. Holman Lebanon Mo

(Licensed Embalmer's Statement on Reverse Side)

S. No. 2
M—2-43
5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1946

Registration District No. 17

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17109

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town LEBANON (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WALLACE HOSPITAL (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community ALWAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County LACLEDE
(c) City or town RURAL (If outside city or town limits, write "RURAL")
(d) Street No. LEBANON PLATO RT. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME TOBITHIA W. COFFMAN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife H C. COFFMAN

6. (c) Age of husband or wife if alive years

7. Birth date of deceased MAR (Month) 22 (Day) 1870 (Year)

8. AGE: Years 76 | Months — | Days 7 | If less than one day hr. min.

9. Birthplace BARREN Co (City, town, or county) Ky. (State or foreign country)

10. Usual occupation HOUSE WIDOW

11. Industry or business

MOTHER FATHER
12. Name JOSEPH EDWARDS
13. Birthplace Ky (City, town, or county) (State or foreign country)
14. Maiden name CATHERINE BOHANNON
15. Birthplace Ky (City, town, or county) (State or foreign country)

16. (a) Informant MRS. REED
(b) Address LEBANON MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-31-46 (Month) (Day) (Year)
(c) Place: burial or cremation BURIAL

18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON

19. (a) 4-8-46 (Date received local registrar) (b) Dee Frankeburger (Registrar's signature)

15 d (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 29
year 1946 hour 8 minute 40 A.M.

21. I hereby certify that I attended the deceased from Mar 25, 1946 to Mar 29, 1946
that I last saw her alive on Mar. 29, 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial failure	6 wks
Due to: Cardiovascular renal disease	Unk
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 1310	
Of autopsy:	

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

23. Signature James A. Hope (M. D. or other)
Address Lebanon, Mo Date signed 4/6/46

.S. No. 300
EV. 10.48

FILED APR 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13432

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 52

0532 0

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

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY, OR TOWN (If outside corporate limits, write RURAL and give township) Lebanon
c. LENGTH OF STAY (In this place) 6 WKS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wallace memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Missouri b. COUNTY Laclede
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lebanon 0532 0
d. STREET ADDRESS (If rural, give location) Mc Phail no house number

3. NAME OF DECEASED (Type or Print) a. (First) Charley b. (Middle) Harrison c. (Last) Chastain

4. DATE OF DEATH (Month) (Day) (Year) April 3, 1952

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	Widowed ?	April 25. 1874	77	11	8		

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)	12. CITIZEN OF WHAT COUNTRY?
Gun Smith	Repairing Guns	Laclede Co. Mo.	U. S. A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
James Chastain	Jaley Rennen	Mary Weaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
no	none	Mrs Will Chastain 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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-sclerotic gangrene left foot — INTERVAL BETWEEN ONSET AND DEATH: 6 moo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) amputation right leg for
DUE TO (c) gangrene on 2/28/52

II. 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?
2/28/52	Arteriosclerotic gangrene right foot	YES ☐ NO ☑

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	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	4501

22. *I hereby certify that I attended the deceased from* 1-31, 1952, to 4-3, 1952, *that I last saw the deceased alive on* 4-2, 1952, *and that death occurred at* 9:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
F. H. Johnson MD	Lebanon Mo	4-5-52

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	4/6/52	New Hope Cemetery	near Ross Laclede Co. Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
4-10-1952	Nella L. Hay 4241.0	W. E. Holman Lebanon, Mo.

(Licensed Embalmer's Statement on Reverse Side)

JL 6

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.

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

Do not use this space.

17598

1. PLACE OF DEATH
County Laclede Registration District No. 449
Township Lebanon Primary Registration District No. 3609
City ..... (No. ..... St. ..... Ward)

File No. 440
Registered No. 472

2. FULL NAME Mary A. Chastain

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chas Chastain

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 14-1873

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	8	8	

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Laclede Co Mo

PARENTS

10. NAME OF FATHER Wesley Weaver
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER Susie Whitson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Laclede Co Mo

14. INFORMANT Stella Chastain
(Address) Lebanon Mo

15. FILED 5/23, 1928 J M Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 22 1928

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1928, to May 22, 1928, that I last saw h. alive on May 22, 1928, and that death occurred, on the date stated above, at 1.30 P. M. on.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
10 Da
Coma
112 Hours
(duration) ✓ yrs. ✓ mos. 10 ds.

CONTRIBUTORY (SECONDARY) Chronic Bronchial Asthma
(duration) 2 yrs. ✓ mos. ✓ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No DATE OF ✓
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? ✓

(Signed) Jno D. Moulder, M. D
May 22, 1928 (Address) Lebanon Mo.

*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	DATE OF BURIAL
Whitson Cemetery	5/24 1928
20. UNDERTAKER Holman & Stewart	ADDRESS Lebanon Mo

NJL 9,81220

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

Do not use this space.

19940

File No. 1298

1. PLACE OF DEATH
County Laclede — Registration District No. 449
Township Lebanon — Primary Registration District No. 0209
City ... (No. ... St. ... Ward)

2. FULL NAME Cecil Daniel

(a) Residence. No. ... St., ... Ward. ... (If nonresident give city or town and State)
(Usual place of abode)
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: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 14 1918

7. AGE: Years 8 | Months 2 | Days 12 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Right Co Mo

PARENTS
10. NAME OF FATHER Chas A Daniel
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Laclede Co Mo
12. MAIDEN NAME OF MOTHER Dora A Hays
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Right Co Mo

14. INFORMANT Chas Daniels
(Address) Lebanon Rt 3 Box 1

15. FILED 6-28 1926 J M Bellamy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-26 1926

17. I HEREBY CERTIFY, That I attended deceased from June 26, 1926 to June 26, 1926, that I last saw him alive on June 26, 1926, and that death occurred, on the date stated above, at 9:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Poisoning I do not know
Exact nature of poison and over
loading stomach Eating Rob Berries
1 hr. (duration) ... yrs. ... mos. 60 hours ... da.

CONTRIBUTORY (SECONDARY) 177
(duration) ... yrs. ... mos. ... da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ...
DID AN OPERATION PRECEDE DEATH? no DATE OF ...
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) J M Gary, M. D
, 19 (Address) Lebanon Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: New Hope Cemetery — DATE OF BURIAL: 6-27 1926

20. UNDERTAKER: Holman & Stewart — ADDRESS: Lebanon

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.

NOV 15 1934

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

Do not use this space.

41734

1. PLACE OF DEATH
County Vernon Registration District No. 875
Township Washington Primary Registration District No. 6162
City ..... (No. ....., ... St. ..... Ward)
File No. .....
Registered No. 318

2. FULL NAME J. C. Coffman
(a) Residence, No. State Hospital # 3 St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ?

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 13, 1869

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
64	8	20	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farming
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER
13. NAME Abner Coffman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER
15. MAIDEN NAME Sarah Couch
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT Mrs. H. C. Coffman Lebanon Mo
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Lebanon Mo DATE Nov. 2 19 34

19. UNDERTAKER Palmer Und. Co
(ADDRESS) Lebanon Mo

20. FILED Nov 2, 1934 M. Eichinger Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 2 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1932, to Nov. 2, 1934
I last saw h. alive on (1) (1), 1934. Death is said to have occurred on the date stated above, at 4:15 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	?
93 d	
91	

Other contributory causes of importance:

Myocardial insufficiency	?
Sudden death	

Name of operation none Date of —
What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
.....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) T. J. Gill, M. D.
(Address) Nevada, 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.

5. No. 2
1—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

DR. HARRELL

STANDARD CERTIFICATE OF DEATH

State File No. 13700

FILED APR 17 1946

Registration District No. 998 — Primary Registration District No. 5630 — Registrar's No. 8

1. PLACE OF DEATH:
(a) County: LACLEDE
(b) City or town: LEBANON Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: LEBANON R.5. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ________ In this community 25 YRS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Laclede
(c) City or town: Lebanon (If outside city or town limits, write "RURAL")
(d) Street No.: Rt. 5 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ________

3. (a) PRINT FULL NAME: DORA ADELINE DANIEL
3. (b) If veteran, name war ________
3. (c) Social Security No. ________
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: WIDOW
6. (b) Name of husband or wife: CHAS. DANIEL
6. (c) Age of husband or wife if alive ________ years
7. Birth date of deceased: OCT (Month) 9 (Day) 1876 (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	5	4	____ hr. ____ min.

9. Birthplace: WRIGHT COUNTY (City, town, or county) MO. (State or foreign country)
10. Usual occupation: HOUSE WIDOW
11. Industry or business ________
FATHER
12. Name: WM SHARP
13. Birthplace: (City, town, or county) TENN (State or foreign country)
MOTHER
14. Maiden name: SUSAN EMERSON
15. Birthplace: (City, town, or county) MO (State or foreign country)
16. (a) Informant: Janie O'Dell
(b) Address: LEBANON Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 3-15-1946 (Month) (Day) (Year)
(c) Place: burial or cremation: NEW HOPE CEM.
18. (a) Signature of funeral director: PALMER'S
(b) Address: LEBANON, Mo.
19. (a) 3-15-46 (Date received local registrar) (b) Ora H. Frankeburger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR. day 13th year 1946 hour 12 minute 30 P.M.
21. I hereby certify that I attended the deceased from 11-20- 1945, to 3-13- 1946; that I last saw her alive on 3-13- 1946; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis & myocardial degeneration — Duration (?)
Due to ________
Due to ________
Other conditions ________ (Include pregnancy within 3 months of death)
Major findings:
Of operations ________
Of autopsy ________

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? ________ (Specify type of place)
While at work? ________ (e) Means of injury ________
23. Signature: R. E. Harrell (M. D. or other) M.D.
Address: Lebanon Mo. Date signed 3-13-46

152

(Licensed Embalmer's Statement on Reverse Side)

AUG 16 1935

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

Do not use this space.

1. PLACE OF DEATH
County Laclede — Registration District No. 449
Township Washington — Primary Registration District No. 5612
City ..... (No. ..... St. ..... Ward)

File No. 23534
Registered No. .....

2. FULL NAME Anna Daniel

(a) Residence, No. ..... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Unmarried

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 8 1912

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	23	6	8	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child at Home
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wright Co Mo

FATHER
13. NAME Charley Daniel
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wright Co Mo

MOTHER
15. MAIDEN NAME Dora Sharp
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co Mo

17. INFORMANT (ADDRESS) Chas - Daniel

18. BURIAL, CREMATION, OR REMOVAL Hearliope Cemetery July 17 1935

19. UNDERTAKER (ADDRESS) Coleman & Stewart Lebanon Mo

20. FILED 7/17, 1935 E. A. McComb Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 16, 1935

22. I HEREBY CERTIFY, That I attended deceased from 7-16, 1935, to 7-16, 1935
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 6 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Gunshot Wound	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Suicide Date of injury 7-16, 1935
Where did injury occur? Home near Lebanon Mo
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Home
Manner of injury Gunshot Wound
Nature of injury Entered between Eyes

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) J. J. Summers Coroner, M. D.
(Address) Lebanon Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

JUN 23 1937

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

Do not use this space.

20492

1. PLACE OF DEATH
County Laclede — Registration District No. 449
Township Lebanon — Primary Registration District No. 5609
File No.
Registered No.
City ... No. 9 ... St. ... Ward) 1

2. FULL NAME G. W. H. Davidson

(a) Residence, No. ... St., ... Ward. ... (If nonresident, give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Ella Davidson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 8 1865

7. AGE — YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
71	11	7	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Minister of Gospel
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hartsville Mo

FATHER
13. NAME Geangewashington Davidson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER
15. MAIDEN NAME Eliza Peters
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) Ella Davidson Oakland Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hesshope Cemetery DATE Apr 17 1937

19. UNDERTAKER (ADDRESS) E. M. Stewart Lebanon Mo

20. FILED 6-12, 1937 J. A. McComb Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 15 1937

22. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1936 to Apr 15, 1937
I last saw him alive on 3-17, 1937. Death is said to have occurred on the date stated above, at 5-9 p. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Myocardetes	

Other contributory causes of importance:
Mytral Regurgetation

Name of operation ... Date of ...
What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) J. W. Hudson, M. D.
(Address) Conway 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.

REGD AUG 25 1938

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

25735
Do not use this space.

1. PLACE OF DEATH
(a) County Laclede — Registration District No. 449
(b) Township [illegible] — Primary Registration District No. 5609 — Registered No.
(c) City Lebanon — (d) Street No. Gallaher Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., If of foreign birth? yrs. mos. ds. 120

2. PRINT FULL NAME Emma Lucretia Davis
(a) Residence, No. Old State Rt. Lebanon Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: Clarence Davis

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Oct 26-1896

7. AGE — YEARS: 41 — MONTHS: 9 — DAYS: 6 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc: House wife
9. Industry or business in which work was done, as saw mill, bank, etc.:
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ross Mo

FATHER
13. NAME: G. H. Lockwood
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ill

MOTHER
15. MAIDEN NAME: Hanna Renner
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ind.

17. INFORMANT (ADDRESS): Clarence Davis Rt 2 Rt. Lebanon Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE New Hope Cemetery DATE July 3 1938

19. FUNERAL DIRECTOR (ADDRESS): Lebanon Mo.

20. FILED 7-7-1938 — J. B. McCourtney, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): July 1 1938

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1938 to July 1, 1938
I last saw her alive on July 1, 1938. Death is said to have occurred on the date stated above, at 7 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of breast following Carcinoma Right Breast	1937
50 Yr	

Other contributory causes of importance:

Name of operation Removal breast Date of May 25 38
What test confirmed diagnosis? Micro Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ....., 19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) H. A. Hamilton, M. D.
(Address) Lebanon, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

5

A X12004

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

PLACE OF DEATH

County Laclede

Township Washington or Village or City

Registration District No. 449 File No. 33320

Primary Registration District No. 5612 Registered No. 244

(NO. ____ St. ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Grace Thompson Davis

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	white	Married

DATE OF BIRTH: Dec (Month) 13 (Day) 1893 (Year)

AGE: 20 yrs. 8 mos. 18 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

BIRTHPLACE (City or town, State or foreign country): Camden Co

PARENTS

NAME OF FATHER: Ed Thompson

BIRTHPLACE OF FATHER (City or town, State or foreign country): Camden Co

MAIDEN NAME OF MOTHER: Marinda Hammer

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Camden Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marinda Thompson

(ADDRESS) Lebanon Mo

Filed Oct 4, 1913. J M Billings REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 4 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 3, 1913, to Oct 4, 1913, that I last saw her alive on Oct 3, 1913, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Congestion of brain

1208

8 11

10 15 (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) Hemorrhage

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J M Billings M. D.

Oct 4 1913 (Address) Lebanon Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

(Former or usual residence)

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Hope Mo	Oct 5 1913
UNDERTAKER: Rees Hickman	ADDRESS

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.

WRITE CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

Do not use this space.

41210

1. PLACE OF DEATH
County Lacledy — Registration District No. 449
Township Washington — Primary Registration District No. 5 6 12
City ... (No. ..., ... St. ..., Ward)

File No. ...
Registered No. ...

2. FULL NAME Harley W Davis

(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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: Mary M Barker

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 28-1861

7. AGE: Years 68 | Months 1 | Days 17 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ...
(c) Name of employer: ...

9. BIRTHPLACE (CITY OR TOWN) ... (STATE OR COUNTRY) Tenn

PARENTS

10. NAME OF FATHER: William A. Davis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ... (STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER: Martha A. Gargus
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ... (STATE OR COUNTRY) Tenn

14. INFORMANT: Jess Davis
(Address) Lebanon

15. FILED 12/14 1929 — J M Brewer — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 15th 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1929 to Dec 15 1929 that I last saw h[illegible] alive on Dec 14 1929, and that death occurred, on the date stated above, at 2 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial-Pneumonia

131

109B (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) Interstitial Nephritis

(duration) 1 yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ...

DID AN OPERATION PRECEDE DEATH? no DATE OF ...

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? ...

(Signed) J. A. Hamilton, M. D

, 19 (Address) Lebanon Mo.

*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: Mt Hope Cemetery — DATE OF BURIAL: 12-17 1929

20. UNDERTAKER: Holman & Stewart — ADDRESS: Lebanon Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

47191

1. PLACE OF DEATH
County Laclede Registration District No. 449 File No.
Township Washington Primary Registration District No. 5212 Registered No. 646
City (No. , St. , Ward)

2. FULL NAME Sarah Arbilla Barton Davis

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	white	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Widow

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-6-1870

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	48	10	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lebanon Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Dr J C Barton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bloomfield
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Athens
(STATE OR COUNTRY) Ills

14. INFORMANT J W Lindsay Only
(Address)

15. FILED 12-21, 1918 J W Bellamy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-19 1918

17. I HEREBY CERTIFY, That I attended deceased from 12-19-18, to 12-19-18, that I last saw h[illegible] alive on 12-19-18, and that death occurred, on the date stated above, at 5-P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
10
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) Pulmonary Tuberculosis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? At place of death
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J W Lindsay, M. D
, 19 (Address) Arla Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New Hope Cem	12-20 1918
20. UNDERTAKER Barnes	ADDRESS

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

Do not use this space

1881

1. PLACE OF DEATH
County Laclede — Registration District No. 449
Township — Primary Registration District No. 4267
City Lebanon (No. ..... St. ..... Ward)

File No. ....
Registered No. 16 16

2. FULL NAME Martha Anna Doran

(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.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully examined before the certificate is filed. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be understood. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF L L Doran

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 15 1843

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	87	8	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Texas

PARENTS

10. NAME OF FATHER Henry Garrigus
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ala
12. MAIDEN NAME OF MOTHER Dant Doran
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Texas

14. INFORMANT Frank Davis
(Address) Ola

15. FILED 1/3, 1930 J M Bellamy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Jan. 2, 1930, that I last saw h[illegible] alive on Nov. 26, 1930, and that death occurred, on the date stated above, at 2 2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of the breast
50
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 50
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J L Burge, M. D.
, 19 (Address) Lebanon Mo

*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	DATE OF BURIAL
New Hope Cemetery	1-4 1930
20. UNDERTAKER	ADDRESS
Holman & Glover	Lebanon Mo

S. No. 300
v. 10-48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39279

BIRTH NO. | FILED NOV 28 1952 | REG. DIST. NO. 170 | PRIMARY REG. DIST. NO. 3033 | Registrar's No. 171

1. PLACE OF DEATH
a. COUNTY: Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lebanon
c. LENGTH OF STAY (in this place): 6 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 252 S. Adams

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Laclede
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lebanon 05 7 E
d. STREET ADDRESS (If rural, give location): 252 S. Adams

3. NAME OF DECEASED (Type or Print): a. (First) Nancy b. (Middle) Emiline c. (Last) Duvall

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 18 1952

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
F	W	Widowed 2	Mar. 20 1870	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?
At. Home		Laclede Co. Mo.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Philip Hawk	Unknown	John Duvall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
NO	—	—	Clarence Duvall	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.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Partial Intestinal obstruction	3 mos.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Large Ventral hernia	10 years.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Senility	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	5613	YES ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan, 1950, *to* Nov 18, 1952, *that I last saw the deceased alive on* Nov 18, 1952, *and that death occurred at* 2.15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. H. Johnson	MD	Lebanon Mo	11/18/52

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 20 1952	New Hope	Laclede Co. Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
11-20-1952	Stella L. Clay	Palmer's	Lebanon Mo.

(Licensed Embalmer's Statement on Reverse Side)

—1/47
5-17-39

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

National Office of Vital Statistics

FILED DEC 4 1947

Registration District No.

STANDARD CERTIFICATE OF DEATH

State File No. 37438

Primary Registration District No. 3012

Registrar's No. 183

1. PLACE OF DEATH:
(a) County nCley
(b) City or town Excelsior Springs, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos. 21 days (Specify whether years, months or days)
In this community 2 mos. 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede 53 1 2
(c) City or town Lebanon
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles H. Duvall
3. (b) If veteran, name war World War
3. (c) Social Security No. Yes-not remembered

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Lizzie Duvall
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased April 12, 1893 (Month) (Day) (Year)

8. AGE: Years 54 | Months 7 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Lebanon (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Realtor and Farmer
11. Industry or business Real estate and Farming

FATHER
12. Name John W. Duvall
13. Birthplace Lebanon (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Nannie Hawk
15. Birthplace Lebanon (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Hospital records, Veterans Administration,
(b) Address Excelsior Springs, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1947 (Month) (Day) (Year)
(c) Place: Removal Lebanon, Mo.

18. (a) Signature of funeral director Chas U Hope
(b) Address HOPE FUNERAL HOME Excelsior Springs, Mo.

19. (a) 11/26/47 (Date received local registrar) (b) Caroline Rutherford (Registrar's signature) 62

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25
year 1947 hour 10 minute 10 P. M.

21. I hereby certify that I attended the deceased from Sept. 4 1947 to Nov. 25 1947
that I last saw him alive on Nov. 25 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Tuberculosis, pulmonary, reinfection type, far advanced, active.	Unknown
Due to	
Due to	
Other conditions... Asthma, bronchial, chronic. (Include pregnancy within 3 months of death)	Unknown

Major findings:
Of operations 13 B
Of autopsy NO AUTOPSY PERFORMED.

PHYSICIAN
Underline the cause of 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 S. C. STROFF (M. D. or other) M.D.
Address Veterans Administration Hospital, Excelsior Springs, Mo. Date signed 11-26-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.

PLACE OF DEATH

County Laclede

Township ____ or Village ____ or City Lebanon (NO. ____ St.: ____ Ward)

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

Registration District No. 449 File No. 16921

Primary Registration District No. 4267 Registered No. 214

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Elbert Franklin Edwards

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	married

DATE OF BIRTH: May (Month) 15 (Day) 1868 (Year)

AGE: 45 yrs. 0 mos. 11 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): 1-0V

BIRTHPLACE (City or town, State or foreign country): Kentucky

PARENTS

NAME OF FATHER: Joseph A. Edwards

BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky

MAIDEN NAME OF MOTHER: Katherine Bohannon

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E B Edwards

(ADDRESS) Lebanon Mo.

Filed May 26, 1913. J M Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 26th (Day) 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from 5/26, 1913, to 5/26, 1913, that I last saw him alive on 5/26, 1913, and that death occurred, on the date stated above, at 7:29 m.

The CAUSE OF DEATH* was as follows:

1. Heart Paralysis
I saw him only 15 m. before death and du
2. Tooth Cam[illegible] Sudden
1 hr (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) L D Casey M. D.

5/26, 1913 (Address) Lebanon Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? ___

Former or usual residence ___

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Hope	5/27, 1913
UNDERTAKER: Russ Heckinan	ADDRESS: Lebanon Mo

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

Do not use this space.

30796

File No.

Registered No. 1396

1. PLACE OF DEATH
County Laclede
Township Washington
City (No. St. Ward)
Registration District No. 449
Primary Registration District No. 5212

2. FULL NAME John South Edwards

(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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mary E. Daniel

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 25 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	71		12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ky.

PARENTS

10. NAME OF FATHER: John B Edwards
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky
12. MAIDEN NAME OF MOTHER: Becky Hardy
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ky

14. INFORMANT: Thompson Edwards
(Address): Lebanon Mo.

15. FILED 10/8, 1927 W H Beeson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 7th 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 7, 1927, that I last saw h. alive on Oct 7, 1927, and that death occurred, on the date stated above, at 12.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma Stomach
(duration) 1 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? No

(Signed) W. A. Hamilton, M. D
, 19 (Address) Lebanon Mo.

*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: New Hope Cemetery
DATE OF BURIAL: 10/8 1927

20. UNDERTAKER: Palmer
ADDRESS: Lebanon

No. 2
1—2-43
5-17-39
X35097

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. F 38527

FILED NOV 18 1943
Registration District No. 170

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WALLACE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY (Specify whether years, months or days)
In this community ALWAYS

2. USUAL RESIDENCE OF DECEASED: (Or place where deceased lived if institutional resident)
(a) State Mo (b) County LACLEDE
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. R. 1. Lebanon Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME LEWIS N. EDWARDS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife OLIVE CARNETT

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased NOV (Month) 10 (Day) 1875 (Year)

8. AGE: Years	Months	Days	If less than one day
67	10	20	hr. min.

9. Birthplace LACLEDE CO (City, town, or county) MO (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

MOTHER FATHER
12. Name JOSEPH EDWARDS
13. Birthplace (City, town, or county) KY (State or foreign country)
14. Maiden name MARYN BOHANON
15. Birthplace (City, town, or county) KY (State or foreign country)

16. (a) Informant Mrs. L. N. Edwards
(b) Address Lebanon Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-3-43 (Month) (Day) (Year)
(c) Place: burial or cremation NEW HOPE CEM

18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON Mo

19. (a) Oct 21-43 (Date received local registrar) (b) Grace Ropp (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 30
year 1943 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept. 29, 1943, to Sept. 30, 1943, that I last saw h... alive on Sept 30, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(a) Pneumonia	
Due to (b) Both Lungs	
Due to	
Other conditions (Include pregnancy within 3 months of death) 33A	

Major findings:
Of operations
Of autopsy no

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

23. Signature L. L. Bennage (M. D.)
Address Lebanon Mo. Date signed 11-4-43

11-18-43

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

JUN 27 1931

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

Do not use this space.

18490

1. PLACE OF DEATH
County Laclede — Registration District No. 449 — File No.
Township Lebanon — Primary Registration District No. 4267 — Registered No. 1657
City .... (No. .... St. .... Ward)

2. FULL NAME Lillian Irene Edwards

(a) Residence, No. .... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ~~May~~ Oct 20 1930
7. AGE — YEARS — MONTHS 7 — DAYS 9 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lebanon Mo.

FATHER
13. NAME Twyman Edwards.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co.

MOTHER
15. MAIDEN NAME Ruth Wagoner
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co

17. INFORMANT Twyman Edwards
(ADDRESS) Lebanon Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE New Hope — DATE 5-31 1931
19. UNDERTAKER Palmer
(ADDRESS) Lebanon Mo
20. FILED June 2 1931 — J. M. Bell[illegible] — Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 29 1931

22. I HEREBY CERTIFY, That I attended deceased from May 28, 1931, to May 29, 1931; I last saw her alive on May 29, 1931. Death is said to have occurred on the date stated above, at 10:45 Am.

The principal cause of death and related causes of importance were as follows: — Date of onset

Perforation of Oesophagus from swallowing pin — 5-27-31

~~Choward~~ 194a 168

Other contributory causes of importance:

Choked

Name of operation .... Date of ....
What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury 5-27, 1931
Where did injury occur? home (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) H. A. Hamilton, M. D.
(Address) Lebanon, Mo

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42988

FILED JAN 17 1941

Registration District No. 449 Primary Registration District No. 4267 Registrar's No.

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

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.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town LEBANON (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: NORTH MADISON (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community SINCE 1881 (Specify whether years, months or days) Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County LACLEDE
(c) City or town LEBANON (If outside city or town limits, write "RURAL")
(d) Street No. N MADISON (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME MARY ELIZEBETH EDWARDS
3. (b) If veteran, name war
3. (c) Social Security No. None

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife J.S. EDWARDS
6. (c) Age of husband or wife if alive years
7. Birth date of deceased NOV (Month) 12 (Day) 1856 (Year)

8. AGE: Years 84 Months 1 Days 16 If less than one day hr. min.

9. Birthplace CLAY CO (City, town, or county) MO (State or foreign country)
10. Usual occupation HOUSE WIFE
11. Industry or business
FATHER 12. Name WM PRUIT
13. Birthplace F (City, town, or county) KY (State or foreign country)
MOTHER 14. Maiden name NOT KNOWN
15. Birthplace NOT KNOWN (City, town, or county) (State or foreign country)
16. (a) Informant's own signature J H Edwards
(b) Address LEBANON MO
17. (a) NEW HOPE CEM (Burial, cremation, or removal) (b) Date thereof DEC 17 1940 (Month) (Day) (Year)
(c) Place: burial or cremation NEW HOPE CEM
18. (a) Signature of funeral director Parnell Hall
(b) Address Lebanon Mo
19. (a) 1-19-41 (Date received local registrar) (b) Jane Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 16 year 1940 hour 5 minute 30 A. M.
21. I hereby certify that I attended the deceased from Dec. 12, 1940, to Dec. 16, 1940 that I last saw h Ea alive on Dec. 16, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchio-pneumonia	4 days.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) DIP	
Major findings: Of operations	
Of autopsy	

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

23. Signature H G. Hamilton (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39

S. No. 2
M—8-43
. 5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 10 1946

State File No. 20843

Registration District No. 170 Primary Registration District No. 3033 Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town LEBANON (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WALLACE HOSPITAL 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 DAYS (Specify whether In this community years, months or days) ALWAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County LACLEDE
(c) City or town LEBANON (If outside city or town limits, write "RURAL") 1
(d) Street No. 710 PEARL ST (If rural, give location) 20
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIAM BURNS EDWARDS
3. (b) If veteran, name war
3. (c) Social Security No. 497-03-3357

4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife CARRIE RENNER
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased AUG (Month) 30 (Day) 1891 (Year)

8. AGE: Years 64 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace LACLEDE Co (City, town, or county) MO (State or foreign country)
10. Usual occupation CARPENTER
11. Industry or business

MOTHER FATHER
12. Name JOHN S. EDWARDS
13. Birthplace (City, town, or county) KY (State or foreign country) 1
14. Maiden name MARY E PRUITT
15. Birthplace (City, town, or county) KY (State or foreign country) 1

16. (a) Informant Esta Edwards
(b) Address LEBANON MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-9-46 (Month) (Day) (Year)
(c) Place: burial or cremation NEW HOPE
18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO
19. (a) June 10, 1946 (Date received local registrar) (b) Ora Frankenberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 7
year 1946 hour 12 minute 15 A.M.
21. I hereby certify that I attended the deceased from June 2, 1946, to June 7, 1946, that I last saw him alive on June 6, 1946, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypertension	
Heart Disease	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Bronchopneumonia	2 days

Major findings:
Of operations
Of autopsy

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

23. Signature J. Brummett (M. D. or Coroner) M.D.
Address Lebanon Mo Date signed 6-8-46

152

(Licensed Embalmer's Statement on Reverse Side)

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

Do not use this space.

29790

1. PLACE OF DEATH
County Greene — Registration District No. 318
Township — Primary Registration District No. 2001
City Springfield Mo — Walnus Hospital St. — Ward)
File No. — Registered No. 619

2. FULL NAME Walter Edwards
(a) Residence No. — St. — Ward.
(Usual place of abode)
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.
(If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: —
6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 24 1897
7. AGE: 28 Years | Months 3 | Days 24 | If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN): Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER: Jo Edwards
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Ky
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Cora Lock
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Ky
(STATE OR COUNTRY)

14. INFORMANT: Jo Edwards
(Address) Morrisville Webster Co Mo
15. FILED 10-19 1925 Ralph J Brooks REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 10/18 1925
17. I HEREBY CERTIFY, That I attended deceased from 10/14 1925 to 10/18 1925, that I last saw him alive on 10/18 1925, and that death occurred, on the date stated above, at 8:50 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Nephritis
11 D.S.
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY): Appendicitis - Ruptured
(duration) ... yrs. ... mos. ... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 10/10 25
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) H Fulbright, M. D.
10/19, 1925 (Address) Springfield Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Nelson Mo
DATE OF BURIAL: 10-19 1925
20. UNDERTAKER: W J Summers
ADDRESS: Ozona Judson

VR Vouno

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

1 PLACE OF DEATH

County Jasper

Township Joplin or Village ... or City Joplin

Registration District No. 411 — File No. 41715

Primary Registration District No. 2062 — Registered No. 720

(NO. St Johns Hospital St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Beatrice Edwards

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fem	white	Married

6 DATE OF BIRTH: July (Month) 7 (Day) 1885 (Year)

7 AGE: 32 yrs. 5 mos. ds. — If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Wright Co Mo Near Mountain Grove

PARENTS

10 NAME OF FATHER: James Brownlee

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky

12 MAIDEN NAME OF MOTHER: Minnie Walton

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Edwards Husband
Joplin 924 Chestnut (Address)

15 Filed Dec 12 1917 J. J. Chenoweth Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 11 (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 7, 1917, to Dec 11, 1917, that I last saw h... alive on Dec 11, 1917, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis Probably ruptured pyosalpinx

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) N C Powers M. D.

Dec 12, 1917 (Address) Joplin Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... ds. — In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lebanon Mo — DATE OF BURIAL: 12 13, 1917

20 UNDERTAKER: W Hurlbut — ADDRESS: Joplin

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

1554

PLACE OF DEATH

County Laclede

Township or Village Washington Russ

Registration District No. 449 File No.

Primary Registration District No. 5612 Registered No. 357

City (NO. St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mussel S. Emery

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: September 22, 1881 (Month) (Day) (Year)

AGE: 33 yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer on Farm,
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Camdin Co, Mo, near Montreal

PARENTS

NAME OF FATHER: Millard Emery

BIRTHPLACE OF FATHER (City or town, State or foreign country): Camdin Co, Mo.

MAIDEN NAME OF MOTHER: Francis Lilly

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Camdin, Co, Mo,

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ira E Lockwood

(ADDRESS) Russ, Mo.

Filed Jan 11, 1915. J M Bellew REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 27 (Day) 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 26, 1914, to Dec 27, 1914, that I last saw h alive on Dec 26, 1914, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

23A 28 (Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) J M Bellew M. D.

(Address) Bolar Mo

Dec 28 1914.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: New Hope Cemetery

DATE OF BURIAL: Dec 28 1914

UNDERTAKER: T B Campbell

ADDRESS: Lebanon, 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.

REC'D FEB 24 1939

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

2800
Do not use this space.

1. PLACE OF DEATH
(a) County LACLEDE — Registration District No. 4-49
(b) Township — Primary Registration District No. 4267 — Registered No.
(c) City LEBANON — (d) Street No. WALLACE HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 430 KATHRYN L. FLOYD
(a) Residence, No. PLATO STAR RT. LEBANON MO
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF DELBERT FLOYD

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAR 21-1913

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..hrs. or ..min.
	25	10	1	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LACLEDE Co. Mo

FATHER
13. NAME Mrs ~~Name~~ JOHN DUVAL
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LACLEDE Co Mo

MOTHER
15. MAIDEN NAME NANNIE HAWK
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LACLEDE Co Mo

17. INFORMANT (ADDRESS) Mrs Griff Duffey Lebanon Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Brew Hope DATE 1 19

19. FUNERAL DIRECTOR (ADDRESS) Pahmeier Lebanon Mo

20. FILED 1-31 1939 J A McCourb Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 26 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1939, to Jan 26, 1939
I last saw h.. alive on Jan 26, 1939. Death is said to have occurred on the date stated above, at 4:20 P m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Staphylococcic Septicemia 1/22/39

Other contributory causes of importance: Picked up with pain on Sunday Home - Injection Ret up

Name of operation — Date of
What test confirmed diagnosis? Blood culture Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ..., 19..
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Home Picked up
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) [illegible] M. D.
(Address) [illegible]

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.

(Licensed Embalmer's Statement on Reverse Side)

S. No. 300
V. 10.48

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

3530
1

FILED MAR 26 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8902

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 5636 Registrar's No. 37

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Washington T.
c. LENGTH OF STAY (in this place) 5. 38 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lebanon Plato Str. Rt.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Mo.
b. COUNTY Laclede
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Washington T. S. 053
d. STREET ADDRESS (If rural, give location) Lebanon Mo. Plato Str. Rt.

3. NAME OF DECEASED (Type or Print) a. (First) Alexander b. (Middle) S c. (Last) Ford

4. DATE OF DEATH (Month) (Day) (Year) Mar. 15 1952

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M 0	W	Married	Mar. 23 1874	77				

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)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Kentucky	U.S.A

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Absolum Ford	Mildred Edwards	Della Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
NO		Mrs. A. S. Ford Lebanon Mo. Plato Str. Rt.

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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis — 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) Mytral Regiritation
DUE TO (c)

II. 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?
	410 X	YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3-9, 1952, *to* 3-15, 1952, *that I last saw the deceased alive on* 3-9, 1952, *and that death occurred at* 3 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J W Hundley MD	Conway Mo	3-17-52

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	3/17 1952	New Hope	Laclede Co. Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
3-19-1952	Della L. Hay 424	Palmer Lebanon mo

(Licensed Embalmer's Statement on Reverse Side)

No. 300
10-48

C

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 19 1956

State File No. 42008

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 197

1. PLACE OF DEATH
a. COUNTY: Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lebanon
c. LENGTH OF STAY (in this place): ✓
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wallace Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Laclede
c. CITY OR TOWN: Lebanon
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒
e. STREET ADDRESS (If rural, give location): Plato Str. Rt. 052 c

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Della	M	Ford	Dec. 11 1956

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
F	W	Widowed	June 19 1888	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Laclede Co. Mo.	U. S. A

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Geo. Lockwood	Hannah Renner	A. S. Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
No		Geo. Ford 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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic changes
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Rectal Pneumonia Left upper Lung field — 11-23-56

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
✓	✓ 443x	YES ☐ NO ☒

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	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* 12-11, 1956, *that I last saw the deceased alive on* 12-10, 1956 *and that death occurred at* 4.00 Pm, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. Summerson M.D.	Lebanon Mo	12-13-56

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/13/56	New Hope	Laclede Co. Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
12-13-1956	Ella L. Day	L. R. Palmer Lebanon Mo

(Licensed Embalmer's Statement on Reverse Side)

424

No. 300
10-46

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26780

50 976-55

BIRTH FILED AUG 30 1955 REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 132

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lebanon
c. LENGTH OF STAY (in this place) 18 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wallace Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Missouri
b. COUNTY Laclede
c. CITY OR TOWN Lebanon
d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐
STREET ADDRESS (If rural, give location) 855 Park Manor

3. NAME OF DECEASED (Type or Print) a. (First) Evelyn b. (Middle) Sue c. (Last) Ford

4. DATE OF DEATH (Month) (Day) (Year) August 17, 1955

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	Aug. 16, 1955				18	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY
None.	None.	Lebanon, Missouri	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Hubert Ford	Bernice Tabor	None.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
No.	None.	Mr. Hubert Ford	Lebanon, Mo.

MEDICAL CERTIFICATION

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.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Bronchial obstruction

II. 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?
	7735	YES ☐ NO ☒

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	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22: *I hereby certify that I attended the deceased from* 8-16-1955 *to* 8-17-1955, *that I last saw the deceased alive on* 8-17-1955, *and that death occurred at* 3:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B B Hurst, M.D.	Lebanon, Mo.	8-18-55

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/18/55	New Hope Cemetery	Laclede County Missouri

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
8-18-1955	Hella L. Clay 424	L. R. Parker	Lebanon mo

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 18 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13745

Registration District No. 170 — Primary Registration District No. 5636 — Registrar's No.

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

1. PLACE OF DEATH:
(a) County LACLEDE Co.
(b) City or town WASHINGTON TOWNSHIP. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Lebanon Mo Plato # 2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 1 Month & 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Lebanon (Rural) (If outside city or town limits, write "RURAL")
(d) Street No. Plato # 2, (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME LARRY GENE FORD
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex MALE
5. Color or race W
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Feb (Month) 12 (Day) 1945 (Year)

8. AGE: Years | Months 1 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Laclede County, (City, town, or county) Missouri (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name George Alvin Ford
13. Birthplace Laclede County, (City, town or county) Missouri (State or foreign country)
14. Maiden name Ora mae Griffin
15. Birthplace Laclede County, (City, town, or county) Missouri (State or foreign country)
16. (a) Informant George Ford
(b) Address R. 1 Star Rte Lebanon Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-45 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope Church,
18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON Mo
19. (a) 3-27-45 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 15
year 1945 hour 5 minute 4 M.
21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...;
that I last saw h... alive on ..... 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Probably Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy

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

23. Signature C. A. Palmer (Coroner) (M. D. or other)
Address Lebanon Mo Date signed 3-16-45

1095

(Licensed Embalmer's Statement on Reverse Side)

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.

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

20626

1 PLACE OF DEATH

County Laclede

Township Washington ~~Osage~~ Lebanon Registration District No. 449 File No.

or

Village Primary Registration District No. 5612 Registered No.

or

City (NO. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George C. Fulford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
M	W	Married

6 DATE OF BIRTH: Nov. (Month) 12 (Day) 1855 (Year)

7 AGE: 62 yrs. 7 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): Farming

9 BIRTHPLACE (City or town, State or foreign country): Michigan

PARENTS

10 NAME OF FATHER: Robert Fulford

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): England

12 MAIDEN NAME OF MOTHER: Jane Bird

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. D. Smith M.D.

(Address) Lebanon Mo.

15 Filed June 28, 1918 J. M. Billings Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 27th (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191..., to ....., 191..., that I last saw h... alive on ....., 191..., and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Struck by Lightning & Killed Instantly.

1 D

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) R. A. Palmer Coroner D.

..., 191... (Address) Lebanon Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Hope Church	7-1-1918

20 UNDERTAKER	ADDRESS
R. A. Palmer	Lebanon. Mo.

No. 300
10-48

0532
1

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34432
State File No.

FILED NOV 15 1954

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 182

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

1. PLACE OF DEATH
a. COUNTY: Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lebanon
c. LENGTH OF STAY (in this place): 34
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 545 S. Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Laclede
c. CITY OR TOWN: Lebanon
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
STREET ADDRESS (If rural, give location): 545 S. Jackson

3. NAME OF DECEASED (Type or Print): a. (First) Margaut b. (Middle) Susan c. (Last) Gulyard

4. DATE OF DEATH: (Month) Oct (Day) 27, (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 25, 1859
9. AGE (In years last birthday): 94 — If UNDER 1 YEAR: Months / Days — If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (City and State or Foreign Country): Laclede County, Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: J. B. Robinson
13b. MOTHER'S MAIDEN NAME: Mary A. McElroy
14. NAME OF HUSBAND OR WIFE: George Gulyard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: Mrs L. Sue Smith Lebanon

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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Infirmities of the Aged. — Age 94

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
4500
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 1937, *to* Oct, 1954, *that I last saw the deceased alive on* 26 Oct, 1954, *and that death occurred at* 4:35 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul A. Jenkins (Degree or title) M.D.
23b. ADDRESS: Lebanon Mo.
23c. DATE SIGNED: 29 Oct 54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/29/54
24c. NAME OF CEMETERY OR CREMATORY: New Hope cemetery
24d. LOCATION (City, town, or county) (State): Rural Missouri

DATE REC'D BY LOCAL REG.: 11-1-1954
REGISTRAR'S SIGNATURE: Nella L. Clay 424
25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: LR Palmer Lebanon Mo

(Licensed Embalmer's Statement on Reverse Side)

. No. 300
. 10-48

532

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

FILED JUN 12 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17279

BIRTH NO. 28952-50 REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 295

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lebanon
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lynn St. No house number

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Missouri
b. COUNTY Laclede
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lebanon 0532
d. STREET ADDRESS (If rural, give location) Rural Brice Rt. 0

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Andy c. (Last) Garr

4. DATE OF DEATH (Month) June (Day) 3 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH June 3, 1950

9. AGE (If under 1 year, last birthday) — If under 1 year: Months — Days — Hours 2. — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Lebanon 0

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Ralph B. Garr

13b. MOTHER'S MAIDEN NAME Pauline J. May

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Ralph B. Garr Lebanon Brice Rt.

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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxia neonatorum — INTERVAL BETWEEN ONSET AND DEATH: 40 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aspiration amniotic fluid
DUE TO (c) Failure of membranes to rupture

II. OTHER SIGNIFICANT CONDITIONS. *Conditions contributing to the death but not related to the disease or condition causing death.* when labor precipitated, 7 L 2 U

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

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) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2:20 A.M., 6-3-50, *to* 3:00 A.M., 6-3-50, *that I last saw the deceased alive on* 6-3-, 19 50, *and that death occurred at* 3:00 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) B B Hurst, M.D.

23b. ADDRESS Lebanon, Mo.

23c. DATE SIGNED 6-5-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 3, 1950

24c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery

24d. LOCATION (City, town, or county) (State) Laclede Co. Mo. near Rissa

DATE REC'D BY LOCAL REG. June 3-1950

REGISTRAR'S SIGNATURE Della L. May 424

25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS No Funeral Director

(Licensed Embalmer's Statement on Reverse Side)

10.300
10.48

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

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29913

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 5568 Register's No. 371

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Independence
c. LENGTH OF STAY (In this place) 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sunset Creek 126 South Claremont

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Lac l ede
c. CITY OR TOWN Lebanon
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) 053 71

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Anna	Belle	Garr	Sept 27, 1955

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	March 9, 1884	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Lacledé Co., Mo	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE	
Francis M. Roberts	Samantha Southard	Andy M. Garr	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
No	None	McRalph Garr	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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma & Metastases — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (Primary in cervix 8 yrs ago)
DUE TO (c) 171X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Gen. Cachexia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept 10, 1955, *to* Sept 27, 1955, *that I last saw the deceased alive on* Sept 25, 1955, *and that death occurred at* 5:45 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	1210 Ash Independence, Mo	9-28-55

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 28, 1955		Hartville Missouri

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
9-28-55	354	D. W. Newcomers Sons	Kansas City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

S. No. 2
M—9-4-41
5-17-39
I X29484

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0
6

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 25 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

6732

State File No.

Registration District No. 170

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede Mo
(b) City or town Harwood [illegible]
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Wallis Moreal 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Harwood 2 days
(Specify whether years, months or days)
In this community Entire life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede 53
(c) City or town Lebanon Star Rout 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country — 0

3. (a) PRINT FULL NAME Sarrah Ellen Ford

3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex M
5. Color or race W 0
6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ______ years

7. Birth date of deceased Sept 7 1888
(Month) Sept (Day) 7 (Year)

8. AGE: Years 54 Months 4 Days 6
If less than one day ______ hr. ______ min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name George Lackwood
13. Birthplace Tailorville Ill (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Hannia Remmer
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Robert Ford
(b) Address Oakland Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1, 15, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Newhope Cem

18. (a) Signature of funeral director E N Stewart
(b) Address Lebanon Mo

19. (a) Jan - 1943 (Date received local registrar) (b) Grace Roper (Registrar's signature)

1090

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13 year 1943 hour 4 minute 30 a. M.

21. I hereby certify that I attended the deceased from Jan 11, 1943 to Jan 13, 1943
that I last saw her alive on Jan 12, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Necropia & gangrene of ilium	4 days
Due to strangulated hernia	5 days
Due to	
1270	

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Ilium stretched root of mesentery gangrenous
Of autopsy

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

23. Signature James L Hope, (M. D. or other)
Address Lebanon, Mo. Date signed 1/14/43

(Licensed Embalmer's Statement on Reverse Side)

S. No. 300
v. 10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32135
State File No.

FILED OCT 9 1952

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 5626 Registrar's No. 1371

1530
4

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, ELDRIDGE
c. LENGTH OF STAY (in this place) 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mathews Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Missouri
b. COUNTY Laclede
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural 05 27
d. STREET ADDRESS (If rural, give location) Mathews Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Malinda c. (Last) Gourley

4. DATE OF DEATH (Month) Sept. (Day) 27, (Year) 1952

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married	Oct. 31, 1864	87				

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)	12. CITIZEN OF WHAT COUNTRY?
at Home		Missouri U	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Dr. J. C. Barker	Nancy E. Tippit	Harve Gourley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
NO			Eldon Campbell, Lebanon, Mo.

MEDICAL CERTIFICATION

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.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma Rt. breast — INTERVAL BETWEEN ONSET AND DEATH: about 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. 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?
	170X	YES ☐ NO ☒

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	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 15, 1952, *to* 9/27, 1952, *that I last saw the deceased alive on* 9/16, 1952, *and that death occurred at* 5.15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jamesd. Hope, M.D.	Lebanon, Mo	10/1/52

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/30/1952	New Hope Cemetery	Laclede Co. Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
10-3-1952	Hilda L. Clay 424	Polmer's Lebanon, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

1 PLACE OF DEATH

County Laclede

Township Washington Registration District No. 449 File No. 16503

or

Village .... Primary Registration District No. 5612 Registered No. 400

or

City .... (NO. .... St.; .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emanuel M Graves

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6 DATE OF BIRTH April (Month) 7 (Day), 1831 (Year)

7 AGE 84 yrs. 1 mos. 13 ds. If LESS than 1 day, ... hrs. or ...... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry business, or establishment in which employed (or employer) ....

9 BIRTHPLACE (City or town, State or foreign country) East Tenessee

PARENTS

10 NAME OF FATHER Henry Graves

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont Know

12 MAIDEN NAME OF MOTHER unk Miller

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L H Graves

(Address) Russ

15

Filed May 18, 1915 J M Billings Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 19 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from April 27, 1915, to May 19, 1915, that I last saw him alive on April 27, 1915, and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of heart

92H

do not know (Duration) ...... yrs. ...... mos. 22 ds.

Contributory (SECONDARY) .... (Duration) ...... yrs. ...... mos. ...... ds.

(Signed) J. A. McComb M. D.

5/20 1915 (Address) Lebanon Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ...... yrs. ...... mos. ...... ds. In the State ...... yrs. ...... mos. ...... ds.

Where was disease contracted if not at place of death? ....

Former or usual residence ....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Hope Cemety	May 20 1915
UNDERTAKER	ADDRESS
Ross Hickman	——

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

86589

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.

1. PLACE OF DEATH

County Lawrence — Registration District No. 449 — File No.

Township [redacted] — Primary Registration District No. [redacted] 4269 — Registered No. 929

City Lebanon (No. ..... St. ..... Ward)

2. FULL NAME Lora Ruth Graves

(a) Residence. No. 313 Michigan Ave St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF L W Graves

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 8. 1870

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	51	10	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Laclede Co. Counties
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER S B F C. Barr

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

12. MAIDEN NAME OF MOTHER Mary Whitson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Fronsdale Co Tenn

14. INFORMANT L W Barr
(Address) Butler, Mo

15. FILED 10/24 1921 J M Bellenger
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 10th 1921

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1921, to Oct 10, 1921, that I last saw h.er alive on Oct 9, 1921, and that death occurred, on the date stated above, at 4 a.m. 3.00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Uterus

Gyn

(duration) 3 mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic exam of

(Signed) P. Thurman, M. D

, 19 (Address) Lebanon

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New Hope — DATE OF BURIAL 10/12 1921

20. UNDERTAKER Palmer — ADDRESS Lebanon

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

Do not use this space.

22664

1. PLACE OF DEATH — County Pike — Registration District No. 213 — Primary Registration District No. 3014 — File No. 175 — Registered No. ____
Township ____ City Jefferson (No. ____, ____ St., ____ Ward)

2. FULL NAME Jno Wesley Harper

(a) Residence No. 1100 Eighth St., ____ Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	married

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Nelle Edwards

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 25 - 1890

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	43	0	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Operator

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Gambling House

10. Date deceased last worked at this occupation (month and year) X — 11. Total time (years) spent in this occupation X

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fort Worth Texas

FATHER

13. NAME Jno Harper

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas

MOTHER

15. MAIDEN NAME No information

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No

17. INFORMANT (ADDRESS) Mrs Nelle Harper 1100 E 8th St

18. BURIAL, CREMATION, OR REMOVAL. PLACE Ben Hur DATE July 27 1933

19. UNDERTAKER (ADDRESS) Lawson & Lawson Mo

20. FILED 8/2/1933 C. R. Bedford Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 24 1933

22. I HEREBY CERTIFY, That I attended deceased from 19 ____ to 19 ____ I did not attend deceased

I last saw h[illegible] alive on July 24 1933 Death is said to have occurred on the date stated above, at 8.30 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Bullet penetrating Cerebellum & Cerebellum	
1 1	1 1
Other contributory causes of importance:	

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Homicide Date of injury 7-24 1933
Where did injury occur? 1102 E 8th St Jefferson City Mo
(Specify city or town, county and State)
Specify whether injury occurred in industry, in home, or in public place. Public Place
Manner of injury Gun shot wound
Nature of injury Penetration of Brain

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify ____

(Signed) Dr. R. E. Wilson Coroner M. D.
(Address) Russellville 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.

AUG 22 1933

AUG 25 1937

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

Do not use this space.

53 2 6

1. PLACE OF DEATH
County Laclede
Township
City Lebanon (No. , St. , Ward)

Registration District No. 449
Primary Registration District No. 4267

File No. 27591
Registered No.

2. FULL NAME Johnny Lee Hufft (Infant)

(a) Residence, No. (Usual place of abode) St., Ward.
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15, 1937

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, 8 hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lebanon Mo.

FATHER

13. NAME Henry Hufft

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co. Mo

MOTHER

15. MAIDEN NAME Lekh Mae Carden

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

17. INFORMANT (ADDRESS) Henry Hufft

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Mear Hoose DATE July 15, 1937

19. UNDERTAKER (ADDRESS) W. E. Holman Lebanon Mo.

20. FILED 7-20-, 1937 J. M. Coulter Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15, 1937

22. I HEREBY CERTIFY, That I attended deceased from 7-15, 1937, to 7-15, 1937

I last saw h. alive on 7-15, 1937 Death is said to have occurred on the date stated above, at 11 a. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Premature	
Other contributory causes of importance: 59	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) J. J. Summers, M. D.
(Address) Lebanon Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 30 1930

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

Do not use this space.

9878

1. PLACE OF DEATH
County Pulaski — Registration District No. 716
Township Jerusalem — Primary Registration District No. 5405
City Crocker (No. ..... St. ..... Ward) — File No. ..... Registered No. 4

2. FULL NAME Lewis Hamilton Graves

(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 2 yrs. 9 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) ~~WIFE OF~~ Russell Barr

6. DATE OF BIRTH (MONTH, DAY AND YEAR) [illegible]

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	6		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Waresaw
(STATE OR COUNTRY) Hickory Co., Missouri

PARENTS

10. NAME OF FATHER Emanuel Graves
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Tennessee
12. MAIDEN NAME OF MOTHER Elizabeth Luthy
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(~~STATE~~ OR COUNTRY) Switzerland

14. INFORMANT Mrs. Edna Kelly
(Address) Crocker, Mo. R 1

15. FILED 4/10 1930 B. J. Kell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 12 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1928, to March 12, 1930, that I last saw h.im alive on March 12, 1930, and that death occurred, on the date stated above, at 5:46 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epithelioma of right face with metastasis involving right eye, prostate gland & bladder (duration) 1 yrs. 6 mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? yes DATE OF Aug. 1928
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) C. Malitz, M. D
Mar. 12 1930 (Address) Crocker, Mo

*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	DATE OF BURIAL
New Hope Cemetery	3/13/30 19
20. UNDERTAKER Hooper & Sons	ADDRESS Crocker, 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.

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

449 V 5552 a

1. PLACE OF DEATH
County Laclede Registration District No. 428 File No. 93
Township Washington Primary Registration District No. 428 Registered No. 111
City Conway (No. ..... St. ..... Ward)

2. FULL NAME Lucinda Idola Johnson

(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 63 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Tige Johnson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 16-1872

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
50	9	22	

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

9. BIRTHPLACE (CITY OR TOWN) Grandview
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Carnaby Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bonus Springs
(STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER Hester Hall
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bonus Springs
(STATE OR COUNTRY) Tenn

14. INFORMANT J V Hough
(Address) Grandview Mo

15. FILED June 1 1923 N B Clinton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 7 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Feb 6, 1923, that I last saw h.. alive on Feb 6, 1923, and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocordelitis
D 30
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J V Hough, M. D
, 19 (Address) Grandview Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Jones Graveyard
DATE OF BURIAL Feb 8 1923
20. UNDERTAKER N B Clinton
ADDRESS Conway 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.

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

1 PLACE OF DEATH

County Laclede

Township Washington — Registration District No. 4449 — File No. 9089

or

Village Bevans — Primary Registration District No. 3912 — Registered No. 876

or

City ..... (No. ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lallie J Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH: July (Month) 11 (Day) 1890 (Year)

7 AGE: 24 yrs. 8 mos. 6 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) Laclede Co Mo

PARENTS

10 NAME OF FATHER J W Scott

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky

12 MAIDEN NAME OF MOTHER Mary Campbell

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) W Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Scott
(Address) Lebanon Mo

15 Filed Mar 2 1915 — J M Billings, Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 17 (Day) 1915 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 2-9-15, 1915, to 2-17, 1915, that I last saw h[illegible] alive on 2-16, 1915, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Burns of Lower Extremities + Hands

(Duration) 0 yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Kinsey M. D.

02-19-1915 (Address) Lebanon Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Hope Cemetery	2-20 1915
20 UNDERTAKER R L Palmer	ADDRESS Lebanon Mo

B—Every item of [illegible] CAUSE OF DEATH [illegible]

MAR 31 1933

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

U. S. NO. 2

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

Do not use this space.

8292

1. PLACE OF DEATH

10?

County Vernon — Registration District No. 875

Township Washington — Primary Registration District No. 6162

City Nevada (No. ..... St. ..... Ward) — File No. ..... Registered No. 51

2. FULL NAME M. D. Johnson

(a) Residence, No. State Hosp # 3 St., ... Ward. (If nonresident, give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Wh.	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Rose Johnson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	75	—	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nashville Tenn.

FATHER

13. NAME — Johnson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) —

MOTHER

15. MAIDEN NAME — —

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) —

17. INFORMANT (ADDRESS) J. Rudy Johnson Dias Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lebanon Mo DATE Feb. 9, 1933

19. UNDERTAKER (ADDRESS) Mark Eichinger Nevada, Mo

20. FILED 2-17, 1933 E. R. King Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 8, 1933

22. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1933 to Feb 8, 1933

I last saw h. alive on Feb 8, 1933 Death is said to have occurred on the date stated above, at 11 00 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
180 M	
93 Chronic Myocarditis	

Other contributory causes of importance:

Stock - Automobile Accident -

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, ~~suicide, or homicide~~? ..... Date of injury Feb 8, 1933

Where did injury occur? Near Stockton, Mo.

(Specify city or town, county, and State)

Specify whether injury occurred in Industry, in home, or in public place. Highway 54

Manner of injury Automobile Accident

Nature of injury Shock - internal injuries

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify .....

(Signed) Laurence L. Cooper, M. D.

(Address) Nevada, Mo.

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

Dr Lee Cox
9 45

1. PLACE OF DEATH
County Greene Registration District No. 318 File No. 23919
Township Springfield Primary Registration District No. 2001 Registered No. 523
City (No. 804 E. Main St. Ward)

2. FULL NAME Ruby Johnson

(a) Residence. No. 814 S Main 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	Col	Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 2. 1918

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
5	3	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Orla
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Virgil Johnson
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Bertie Lewis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs Isabel Lewis
(Address) Orla Mo

15. Aug 7, 1923 Chas F Green REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/5 1923

17. I HEREBY CERTIFY, That I attended deceased from 8/1, 1923, to 8/5, 1923, that I last saw h[illegible] alive on 8/4, 1923, and that death occurred, on the date stated above, at 9:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septic Endocarditis 88
91 A
115 L
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Probably direct Tonsils
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Lee Cox, M. D
8/5, 1923 (Address) 726 Landes Blk

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Ebenezer Mo	Aug 6 1923
20. UNDERTAKER	ADDRESS
Johnson & Reed Co	534 St Louis

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.

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

Do not use this space.
26851

1. PLACE OF DEATH
53 County Laclede — Registration District No. 95-2
Township Franklin — Primary Registration District No. 5617
File No.
Registered No.
City ... (No. ... St. ... Ward)

2. FULL NAME Rosa Ellen Johnson

(a) Residence, No. ... St., ... Ward. ... (If nonresident, give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF M. E. Johnson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 17 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	76	6	1	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Home-wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co Mo

FATHER
13. NAME Jessie Brakefield
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas

MOTHER
15. MAIDEN NAME Cinnie Ellen Brakefield
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas

17. INFORMANT (ADDRESS) Marion Johnson Lebanon Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Newhope Cemetery DATE Aug 20 1933

19. UNDERTAKER (ADDRESS) Hellman & Calvert Lebanon Mo

20. FILED Aug 19 33 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 18 1933

22. I HEREBY CERTIFY, That I attended deceased from April 12, 1932 to Aug 18 1933
I last saw her alive on July 6 1933 Death is said to have occurred on the date stated above, at 3 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
General arteriosclerosis	
Valvular heart disease	
Angina pectoris	
Nephritis Main cause	
Other contributory causes of importance:	
Liver cirrhosis	

Name of operation ... Date of ...
What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ...
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...
(Signed) T. F. Casey, M. D.
(Address) Lebanon 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.

SEP 26 1933

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County Laclede

Township Washington or Village ______ or City ______ (NO. ______ St.; ______ Ward)

Registration District No. 4449 File No. 25033

Primary Registration District No. 5612 Registered No. ______

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Dorthy Jones

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX: Femal — COLOR OR RACE: white — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): ~~married~~ single	DATE OF DEATH: Sept (Month) 30 (Day), 1911 (Year)
DATE OF BIRTH: Sept (Month) 30 (Day), 1911 (Year)	I HEREBY CERTIFY, that I attended deceased from ______, 1911, to ______, 1911, that I last saw her alive on Sept 30, 1911, and that death occurred, on the date stated above, at 3 p.m.
AGE: one hour yrs., ___ mos., ___ ds. If LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: Boone at seventh month of gestation do not know cause
OCCUPATION (a) Trade, profession, or particular kind of work: non (b) General nature of industry, business, or establishment in which employed (or employer): none	153 / 51 (Duration) ___ yrs. ___ mos. ___ ds.
BIRTHPLACE (City or town, State or foreign country): Washington	Contributory (SECONDARY) ______ (Duration) ___ yrs. ___ mos. ___ ds.
PARENTS — NAME OF FATHER: Isiac Elmer Jones	(Signed) J. B. Barker M. D.
BIRTHPLACE OF FATHER (City or town, State or foreign country): washington Township	Oct 1, 191__ (Address) Lebanon
MAIDEN NAME OF MOTHER: Lotte May Ogsion	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Franklin Township	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	Where was disease contracted if not at place of death? ______
(Informant) J. B. Barker	Former or usual residence ______
(ADDRESS) Lebanon	PLACE OF BURIAL OR REMOVAL: Neo Byer — DATE OF BURIAL: Oct 1, 1911
Filed Oct 1 1911. J M Billings REGISTRAR	UNDERTAKER: none — ADDRESS: ✓

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

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.

PLACE OF DEATH

County Laclede

Township or Village Washington Road

or City ____ (NO. ____ St.: ____ Ward)

Registration District No. 449 File No. 32673

Primary Registration District No. 56 12 Registered No. 347

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Henry S Jones

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH July (Month) 17 (Day) 1880 (Year)

AGE 34 yrs. 2 mos. 24 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Well Drilling & farming

(b) General nature of industry, business, or establishment in which employed (or employer) drilling for water

BIRTHPLACE (City or town, State or foreign country) Lebanon Mo

PARENTS

NAME OF FATHER Jas H Jones

BIRTHPLACE OF FATHER (City or town, State or foreign country) Lebanon Mo

MAIDEN NAME OF MOTHER Frona A Garrett

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Georgia A Jones

(ADDRESS) Route 1

Filed Oct-15 1914 J M Phillips REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct (Month) 11 (Day) 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 4, 1914, to Oct 10, 1914, that I last saw h— alive on Oct 10, 1914, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

~~Fthe~~ Phtesis Pulmanals

23A 78

(Duration) 10 yrs. 8 mos. 7 ds.

Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J M Phillips M. D.

10-13 1914 (Address) Arly Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Hope	Oct 12 1914

UNDERTAKER	ADDRESS
Russ Hickman	Lebanon

FEB 17 1937

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

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1979

File No.

Registered No.

1. PLACE OF DEATH
County Laclede Registration District No. 449
Township Washington Primary Registration District No. 5612
City (No. 70 St. Ward)

2. FULL NAME Marilyn Belle Jones

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 27-1936

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	1	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Infant

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co Mo

FATHER

13. NAME John Jones

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co Mo

MOTHER

15. MAIDEN NAME Velma Southard

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co Mo

17. INFORMANT (ADDRESS) Edgar Dewaspure Lebanon Mo State R

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hazelhope Cemetery DATE Jan 6- 1937

19. UNDERTAKER (ADDRESS) E N Hebert Lebanon Mo

20. FILED 1-6-1937 J A McCourb Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 4 1937

22. I HEREBY CERTIFY That I attended deceased from Jan 4 to Jan 4 1937

I last saw her alive on Jan 4 1937 Death is said to have occurred on the date stated above, at 10 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Influenza	

Other contributory causes of importance:

Convulsions	

Name of operation Date of

What test confirmed diagnosis? Physical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. L. Scott, M. D.

(Address) Lebanon, 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.

Label and statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Laclede

Township Washingint Registration District No. 449 File No. 6 38313

or Village Primary Registration District No. 5612 Registered No.

or City (No. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lottie Jones

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX: Femele — COLOR OR RACE: White — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married	DATE OF DEATH: Nov (Month) 12 (Day), 1911 (Year)
DATE OF BIRTH: Nov (Month) 12 (Day), 1911 (Year)	I HEREBY CERTIFY, that I attended deceased from Aug 1, 1911, to 3 months Nov 5, 1911, that I last saw her alive on Nov 5, 1911, and that death occurred, on the date stated above, at 11 P m.
AGE: 21 yrs. mos. ds. If LESS than 1 day, hrs. or min.?	The CAUSE OF DEATH* was as follows:
OCCUPATION (a) Trade, profession, or particular kind of work: Farmer	Tuberlosis Lungs
(b) General nature of industry, business, or establishment in which employed (or employer): 9-10	Tuberlosis pure Consuption Father & Mother died of same
BIRTHPLACE (City or town, State or foreign country): Franklin Township	(Duration) 9 yrs. mos. ds.
NAME OF FATHER: Isaac Oguim	Contributory (Secondary) (Duration) yrs. mos. ds.
BIRTHPLACE OF FATHER (City or town, State or foreign country): Franklin Township	(Signed) J C Barker M. D. Nov 13, 1911 (Address) Lebanon Mo
MAIDEN NAME OF MOTHER: Martha Oguim	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Franklin Towns-	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J F Burker	Where was disease contracted if not at place of death?
(ADDRESS) Lebanon Mo	Former or usual residence
Filed Nov 13, 1911 J M Billings REGISTRAR	PLACE OF BURIAL OR REMOVAL: New hope cemetery — DATE OF BURIAL: Nov 14, 1911 — UNDERTAKER: Ross Hickman — ADDRESS: Lebanon Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

9283

File No.

Registered No. B336

1. PLACE OF DEATH
County Laclede Registration District No. 449
Township Washington Primary Registration District No. 5612
City (No. St. Ward)

2. FULL NAME Mable James

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1-1908

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	21	9	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Girl at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Laclede Co Mo

PARENTS

10. NAME OF FATHER Ben Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Laclede Co Mo
12. MAIDEN NAME OF MOTHER Emma Gardner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Laclede Co Mo

14. INFORMANT Earney James
(Address) Russ Fork Mo

15. FILED 3/7, 1930 J. M. Billiney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 7 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929 to March 5, 1930
that I last saw her alive on May 1, 1929, and that
death occurred, on the date stated above, at Mt Vernon m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
9 3 D

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH —
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam
(Signed) C. O. Thompson, M. D.
, 19 (Address) Lebanon Mo.

*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	DATE OF BURIAL
Hazelhope Cemetery	3/8 1930
20. UNDERTAKER	ADDRESS
Holman & Stewart	Lebanon Mo

MAR 26 1927

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

1. PLACE OF DEATH
County Laclede
Township Lebanon
City .... (No. .... St. .... Ward)

Registration District No. 449
Primary Registration District No. 5609

File No. 8706
Registered No. 1347

2. FULL NAME Matilda Kendall

(a) Residence. No. .... St. .... Ward. (If nonresident give city or town and State)
(Usual place of abode)
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 F
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Maried
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Derrick Kendall
6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 19-1857
7. AGE Years 68 Months 10 Days 16 If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Berry Co Mo

PARENTS
10. NAME OF FATHER Martin Hiftens
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) West Va
12. MAIDEN NAME OF MOTHER Martha Hudson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Berry Co Mo

14. INFORMANT Charlie Kendall
(Address) Lebanon Mo R° 112

15. FILED 3/7 1927 J M Bllings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 5, 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1926, to March 5, 1927 that I last saw her alive on Feb. 25, 1927, and that death occurred, on the date stated above, at 7:10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
(duration) ... yrs. 2 mos. ... ds.
CONTRIBUTORY (SECONDARY) arteriosclerosis
(duration) 4 yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) H. A. Hamilton, M.D
, 19 (Address) Lebanon, Mo.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New Hope Cemetery
DATE OF BURIAL 3/7 1927
20. UNDERTAKER Holman & Stewart
ADDRESS Lebanon 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.

APR 30 1930

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

Do not use this space.

9282

File No.

Registered No. 1538

1. PLACE OF DEATH
County Laclede
Township Lincolnshire
City (No. St. Ward)
Registration District No. 449
Primary Registration District No. 4492

2. FULL NAME George Harrison Lockwood

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W.	Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Hannah Rennie

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 7-1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	68	2	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Isiac Lockwood
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ill.
12. MAIDEN NAME OF MOTHER Sarah Dunbar
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill.

14. INFORMANT Mrs. G. H. Lockwood
(Address) Rush Mo.

15. FILED 3/16 1930 J M Billings REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 16 1930

17.
I HEREBY CERTIFY, That I attended deceased from March 12, 1930 to Mar. 16, 1930 that I last saw him alive on Mar. 12, 1930, and that death occurred, on the date stated above, at 9:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) arterio-sclerosis - Rheumatism

(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W. A. Hamilton M. D.
, 19 (Address) Lebanon, Mo

*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	DATE OF BURIAL
New Hope	3/18 1930
20. UNDERTAKER Palmer	ADDRESS Lebanon Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

MAY 27 1937

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

Do not use this space.

File No. 16767

Registered No.

1. PLACE OF DEATH
County Laclede Registration District No. 449
Township Washington Primary Registration District No. 5617
City (No. St. Ward)

2. FULL NAME Emma L. Lockwood

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Ell Lockwood

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 24 1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	61	11	8	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Near Drynob Mo

FATHER
13. NAME J. C. Barker
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

MOTHER
15. MAIDEN NAME Nancy Tillett
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

17. INFORMANT (ADDRESS) Ell Lockwood Buck Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE New Hope Cemetery Apr 13, 1937

19. UNDERTAKER E. N. Stewart
(ADDRESS) Lebanon Mo

20. FILED 4-13-, 1937 J. A. McComb
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 12, 1937

22. I HEREBY CERTIFY, That I attended deceased from Mch 7, 1937, to April 12, 1937
I last saw h... alive on 3-2-, 1937. Death is said to have occurred on the date stated above, at 8 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cancer of liver	

Other contributory causes of importance:

Name of operation... Date of...
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury..., 19...
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) J. A. McComb, M. D.
(Address)

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.

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

MAY 29 1935

Do not use this space.

9646

1. PLACE OF DEATH
County Laclede — Registration District No. 449
Township Washington — Primary Registration District No. 5612
City ..... (No. ..... St. ..... Ward)
File No. .....
Registered No. .....

2. FULL NAME Hannah P. Lakewood

(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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	White	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF J. H. Lakewood

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 15 - 1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	75	0	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Work

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Orphanstown Ind.

FATHER

13. NAME A. M. Penner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) U. S.

MOTHER

15. MAIDEN NAME Marguerite Briton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) U. S.

17. INFORMANT Mrs Clarence Davis Conway Mo.
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Ben Hur / DATE 4 - 1 - 1935

19. UNDERTAKER Palmer & Conway
(ADDRESS)

20. FILED 4/1 1935 J. A. McCourt
Registrar.

2-22-22

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 30, 1935

22. I HEREBY CERTIFY, That I attended deceased from 3-27, 1935, to 3-30, 1935
I last saw h.e. alive on 3-28, 1935 Death is said to have occurred on the date stated above, at 4 a. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia (Bronchial)	
n/a	

Other contributory causes of importance: Fever

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. .....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) J. W. Lindsay, M. D.
(Address) Conway

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3122

Registration District No. 4-14 FEB 24 1941

Primary Registration District No. 4267

Registrar's No.

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.

1. PLACE OF DEATH:
(a) County Laclede 53
(b) City or town Lebanon Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
(Specify whether
In this community — years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede 53
(c) City or town Rural Route 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. Near Russ Mo
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Isaac Lockwood
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex M
5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Sept (Month) 7 (Day) 1873 (Year)

8. AGE: Years 67 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Ill (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business —
FATHER
12. Name Isaac Lockwood
13. Birthplace Ill (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah Dunbar
15. Birthplace Ill (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Mrs. Ray Bradshaw
(b) Address Lebanon Mo Rt 2.
17. (a) — (Burial, cremation, or removal) (b) Date thereof 1-22-41 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope
18. (a) Signature of funeral director E N Stewart
(b) Address Lebanon Mo
19. (a) 1-20-41 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 19
year 1941 hour 9 minute 0 A. M.
21. I hereby certify that I attended the deceased from 1-18 1941, to 1-19 1941;
that I last saw h[illegible] alive on 1-19 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	
Due to [illegible]	1-2 hr.
Due to —	
Other conditions (Include pregnancy within 3 months of death) Diabetis Mellitus Lobar Pneum. Rt Lower Lobe	10 yrs.

PHYSICIAN

Major findings:
Of operations —
Of autopsy —

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? —
(Specify type of place)
While at work? — (e) Means of injury —
23. Signature Paul A Jenkins (M. D. or Other)
Address Lebanon Mo Date signed 1-20

(Licensed Embalmer's Statement on Reverse Side)

S. No. 2
M—5-43
. 5-17-39
» 1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1947

Registration District No. 140

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17927

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town LEBANON (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: WALLACE HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)

In this community ALWAYS

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County LACLEDE 53

(c) City or town LEBANON (If outside city or town limits, write "RURAL")

(d) Street No. R. 1 [redacted] (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME VERNA O'DELL

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CLAUDE R. O'DELL

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased JUNE (Month) 15 (Day) 1894 (Year)

8. AGE: Years 52 | Months 11 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace LACLEDE Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business

MOTHER

12. Name H. C. COFFMAN

13. Birthplace LACLEDE Co (City, town, or county) Mo (State or foreign country)

MOTHER

14. Maiden name TABITHA EDWARDS

15. Birthplace (City, town, or county) Ky (State or foreign country)

16. (a) Informant C. R. O'Dell

(b) Address LEBANON MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-1-47 (Month) (Day) (Year)

(c) Place: burial or cremation NEW HOPE CEM.

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO.

19. (a) 6-7-1947 (Date received local registrar) (b) Ora Frankenberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 30

year 1947 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from July 15 1946 to May 30 1947; that I last saw her alive on May 30 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: hemiplegia	9 hrs
Due to: metastatic adenocarcinoma to brain	3 hrs
Due to: adenocarcinoma vulva	9 mos
Other conditions: (Include pregnancy within 3 months of death)	

Major findings: Of operations: adenocarcinoma vulva metastatic ac. ing glands

Of autopsy: +50

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature James L. Hope, (M. D. ~~or other~~)

Address Lebanon, Mo. Date signed 6/4/47.

(Licensed Embalmer's Statement on Reverse Side)

No. 2
-1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 31 1947

Registration District No. 7-28

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24667

Primary Registration District No. 3033

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community entire life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Lebanon
(If outside city or town limits, write "RURAL")
(d) Street No. north Adams
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joseph Marion O'Quinn
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex male
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Allie O'Quinn
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased May (Month) 26 (Day) 1863 (Year)

8. AGE: Years 84 Months 1 Days 19 If less than one day hr. min.

9. Birthplace Laclede Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Retired farmer
11. Industry or business
FATHER
12. Name John O'Quinn
13. Birthplace Kentucky (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah Phipps
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Allie O'Quinn
(b) Address Lebanon Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-47 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope Cemetery
18. (a) Signature of funeral director W. E. Holeman
(b) Address Lebanon Mo.
19. (a) 7-26-1947 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1947 hour 10 minute P.M.
21. I hereby certify that I attended the deceased from July 9 1947 to July 15 1947, 19....; that I last saw h.... alive on July 15 1947, 19....; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death
Cerebral Hemorrhage — 6 days
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Paul A Jackins MD (M. D. or other)
Address Lebanon Mo. Date signed July 16 1947

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

PLACE OF DEATH

County Laclede

Township Washington or Village or City

Registration District No. 449 File No. 66 38312

Primary Registration District No. 5712 Registered No.

(NO. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Sarah Lockwood

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

DATE OF BIRTH: Nov (Month) 4 (Day) 1831 (Year)

AGE: 80 yrs. mos. 11 ds.

IF LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

BIRTHPLACE (City or town, State or foreign country): Virginia (East)

PARENTS

NAME OF FATHER: Daniel Dunbar

BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia

MAIDEN NAME OF MOTHER: Do not know Hendrix

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J E Lockwood

(ADDRESS) Ross Mo

Filed Nov 11, 1911 J M Bunting REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 11 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 30 1910, to Nov 11 1911, that I last saw b alive on , 191 , and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows: Nov 11- 1911.

Supposed to be Dementia From senile causes

Duration 4 yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) J M Bunting Practicing Physician M. D.

Nov 11, 1911 (Address) Lebanon Dist 449

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: New Hope

DATE OF BURIAL: Nov 19 1911

UNDERTAKER: Ross Hutchcraft

ADDRESS: Lebanon

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

Do not use this space.
27992
3387

1. PLACE OF DEATH
County Jackson Registration District No. 399
Township Blue Primary Registration District No. 1002 File No.
City Leeds Mo. (No. Leeds Hospital St. Ward) Registered No.

2. FULL NAME Mrs. Sary Lockwood

(a) Residence. No. 5110 6. 11th St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married
5a. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF: Perry Lockwood
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 18 1899
7. AGE — YEARS: 29 | MONTHS: 10 | DAYS: 18 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: James Chastain
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY):
12. MAIDEN NAME OF MOTHER: Ida Adams
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri

14. INFORMANT: R. C. Sulivan Husband
(Address) Leeds, Mo.
15. FILED 8/30, 1929 M. M. Crowe asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): August 30 1929
17. I HEREBY CERTIFY, That I attended deceased from June 21 1929 to August 30 1929
that I last saw her alive on August 29 1929, and that death occurred, on the date stated above, at 8 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) George C. Lee, M. D
8/30, 1929 (Address) 1002 Argyle Bldg. K.C. Mo.

*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: Lewisan Mo
DATE OF BURIAL: Aug. 31 1929
20. UNDERTAKER: John W Wagner
ADDRESS: 1408 Grandave.

S. No. 2
M—5-43
. 5-17-39
I X38671

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

53
2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 2 1947

Registration District No. 190

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17928 State File No.

Primary Registration District No. 2033

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
121 BLAND AVE /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 50 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE 53

(c) City or town LEBANON /
(If outside city or town limits, write "RURAL")

(d) Street No. 121 BLAND AVE 2
(If rural, give location) 0

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME HARVEY B OWENS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MARY JOHNSON

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased JULY (Month) 6 (Day) 1877 (Year)

8. AGE:

Years	Months	Days	If less than one day
69	10	7	hr. min.

9. Birthplace WRIGHT Co (City, town, or county) MO 0 (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

FATHER
12. Name WM. OWENS
13. Birthplace TENN. / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MARY P FLETCHER
15. Birthplace N C / (City, town, or county) (State or foreign country)

16. (a) Informant MRS H. B. Owens

(b) Address LEBANON MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-15-47 (Month) (Day) (Year)

(c) Place: burial or cremation NEW HOPE CEM

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) May 24, 1947 (Date received by local registrar) (b) Otis Frankenberger (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month MAY day 13
year 1947 hour 2 minute as PM

21. I hereby certify that I attended the deceased from 3-19, 1947, to 5-12, 1947
that I last saw h[illegible] alive on 5-12, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Endocarditis	
Due to Chronic valvular heart disease.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations NONE / Of autopsy	

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? (Specify type of place) /

While at work? (e) Means of injury

23. Signature Austin R. Brown (M. D. or other) D.O.

Address Lebanon, Mo. Date signed 5/29/47

(Licensed Embalmer's Statement on Reverse Side)

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.

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

PLACE OF DEATH

County Texas

Township Roubidoux — Registration District No. 867 — File No. 3413

or Village — Primary Registration District No. 6147 — Registered No.

or City ____ (No. ____ St.: ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Harvey Bruce Owens

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH May — 27th (Month) (Day), 1914 (Year)

AGE 1 yrs. 4 mos. 18 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ____
(b) General nature of industry, business, or establishment in which employed (or employer) ____

BIRTHPLACE (City or town, State or foreign country) Plato, Mo

PARENTS

NAME OF FATHER Harvey Broady Owens

BIRTHPLACE OF FATHER (City or town, State or foreign country) Hartville Wright Co. Mo

MAIDEN NAME OF MOTHER Mary Ellen Johnson

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Scotland Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Owens

(ADDRESS) Plato Mo

Filed Oct- 15th 1914 R. B. Lynch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH October - 15th (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct- 5th, 1914, to Oct- 15th, 1914, that I last saw him alive on Oct- 15th, 1914, and that death occurred, on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

107 A

(Duration) 11 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ?

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Robt. B. Tilley M. D.

Oct- 15th 1914 (Address) Plato, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Hope Cemetery	Oct 16 1914
UNDERTAKER	ADDRESS
Geo. P. Breakfield	Russ, Mo.

No. 300
10-48

53
1
2

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

3033 State File No. 16134

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 5-630 Registrar's No. 78

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY OR TOWN Lebanon
c. LENGTH OF STAY (In this place) 58 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Laclede 53
c. CITY OR TOWN Lebanon Rural Rt. #5 0
d. STREET ADDRESS (If rural, give location) Rt. 5 0

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Mary	ELLEN	Owen		5	18	49

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Fe.	White	Widowed 21	1/27/1880	69	3	21		

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)	12. CITIZEN OF WHAT COUNTRY?
Home maker		Laclede Co. Missouri 0.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Martin D. Johnson	Rose Brakefield	H. B. Owen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
		Mrs. Charles Simpson, 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.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary occlusion	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	"	
DUE TO (c)	"	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	Hypertensive heart disease	4 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* " , 19___, *to* 1-16, 1949, *that I last saw the deceased alive on* 1-16, 1949, *and that death occurred at* 11 46 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. A. C. Graves D.O.	Lebanon, Mo.	May 21 '49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	5/23/49	New Hope	Laclede Co. Missouri

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
5/22/49	Della L. Klay 4240	Palmer Funeral Home Lebanon Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County Laclede

Township Washington or Village [redacted] or City _____ (No. _____ St.: _____ Ward)

Registration District No. 449 File No. 20520

Primary Registration District No. 561E Registered No. 107

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Edward E Pyle

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH May 30, 1864 (Month) (Day) (Year)

AGE 47 yrs. 11 mos. 29 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

BIRTHPLACE (City or town, State or foreign country) Hattonsburg Mo

PARENTS

NAME OF FATHER Wm. B. Pyle

BIRTHPLACE OF FATHER (City or town, State or foreign country) Chilicothe Ohio

MAIDEN NAME OF MOTHER Ella Lowery

BIRTHPLACE OF MOTHER (City or town, State or foreign country) N.C.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse H. B. Tillery

(ADDRESS) Route No 8

Filed June 3, 1912 J M Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 29 (Month) (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from May 14, 1912, to May 28, 1912, that I last saw him alive on May 28, 1912, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Rectum

Fistula Ano

25 (Duration) 37 yrs. ___ mos. 14 ds.

1736

Contributory (Secondary) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J M Lindsay M. D.

5-29 1912 (Address) Arlington

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Near Hohn Cem — DATE OF BURIAL May 30, 1912

UNDERTAKER [illegible] — ADDRESS [illegible]

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2665

FILED JAN 30 1942

Registration District No. 7

Primary Registration District No. 5612

Registrar's No.

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

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town WASHINGTON TWP (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: LEBANON, PLATO STAR RT. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 20 YRS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE

(c) City or town RURAL (If outside city or town limits, write "RURAL")

(d) Street No. LEBANON PLATO STAR, RT. (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME FRED T. RANDLES

3. (b) If veteran, name war

3. (c) Social Security No. 486-16-1005

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ADA EDWARDS

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased APR (Month) 5 (Day) 1883 (Year)

8. AGE: Years	Months	Days	If less than one day
58	9		hr. min.

9. Birthplace COON RAPIDS (City, town, or county) / IOWA (State or foreign country)

10. Usual occupation FARMER & LABORER

11. Industry or business

MOTHER FATHER

12. Name HADLEY RANDLES

13. Birthplace (City, town, or county) / IND (State or foreign country)

MOTHER

14. Maiden name MARGARET EVANS

15. Birthplace (City, town, or county) / IND (State or foreign country)

16. (a) Informant Mrs. Fred T. Randles

(b) Address Plato Rt. LEBANON MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-7-41 (Month) (Day) (Year)

(c) Place: burial or cremation NEW HOPE CEM.

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) Jan. 5 1942 (Date received local registrar) (b) Grace Rapp (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 5

year 1942 hour 8 minute 50 A.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;

that I last saw h alive on , 19 ;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ACCUTE INDIGESTION	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature James D Stanton (M.D. or other) Coroner

Address Lebanon MO Date signed 1-8-42

10-10 (Licensed Embalmer's Statement on Reverse Side)

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

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.

1 PLACE OF DEATH
County Laclede
Township or Village Washington
City (NO. St. Ward)
Registration District No. 449 File No. 24910
Primary Registration District No. 5612 Registered No. 467
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alfred Young Roberts

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single
6 DATE OF BIRTH: Feb 22 (Month) (Day) 1887 (Year)
7 AGE: 29 yrs. 3 mos. 11 ds. If LESS than 1 day ..... hrs. or ..... min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry business or establishment in which employed (or employer): Farm
9 BIRTHPLACE (City or town, State or foreign country): Ozla Mo

PARENTS
10 NAME OF FATHER: Francis Marion Roberts
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill
12 MAIDEN NAME OF MOTHER: Samantha J Southard
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Morris Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samantha Roberts
(Address) Russ Mo.

15 Filed July 15 1916 J M Billings Registrar

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH: June (Month) 8 (Day), 1916 (Year)
17 I HEREBY CERTIFY, that I attended deceased from 6-6, 1916, to 6-8, 1916,
that I last saw h[illegible] alive on 6-8, 1916,
and that death occurred, on the date stated above, at 12 A m.
The CAUSE OF DEATH* was as follows:
1 Peritonitis cause from ruptured bowel abdomen
(Duration) ..... yrs. 2 days mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J W Lindsey M. D.
6-9, 1916. (Address) Ozla Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Hope Cemetery — DATE OF BURIAL: 6-9, 1916
20 UNDERTAKER: Richard Palmer — ADDRESS: Lebanon Mo.

WHITE PERMANENT RECORD — TO BE FILLED OUT WITH UNFADING INK — THIS COPY FOR PERMANENT RECORD

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.

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

PLACE OF DEATH

County Laclede

Township or Village Washington / Russ

Registration District No. 449 — File No. 34663

Primary Registration District No. 56 12 — Registered No.

City ____ (No. ____ St.: ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John H Roberts

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	married

DATE OF BIRTH: October (Month) 17th (Day) 1882 (Year)

AGE: 28 yrs. 0 mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Ruse, Laclede Co. Mo.

PARENTS

NAME OF FATHER: F. M. Roberts

BIRTHPLACE OF FATHER (City or town, State or foreign country): Illinois

MAIDEN NAME OF MOTHER: Samantha Southard

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Maries Co. Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Beatrice Edwards

(ADDRESS) Ruse, Mo.

Filed Nov. 18. 1910. J M Billings REGISTRAR

J E Bachmann Asst Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov 17 (Month) (Day), 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 1, 1910, to Nov 17, 1910, that I last saw h[illegible] alive on Nov 16, 1910, and that death occurred on the date stated above, at 4 A m.

The CAUSE OF DEATH was as follows:

Typhoid Fever

103 B

(Duration) ____ yrs. ____ mos. 17 ds.

Contributory (Secondary) Hemorrhage

(Duration) ____ yrs. ____ mos. 1 ds.

Signed) O W Lindsay M. D.

11-17 1910 (Address) Cedar Bro

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 3 yrs. ____ mos. ____ ds. In the State 28 yrs. 1 mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: New Hope Graveyard

DATE OF BURIAL: Nov 17 1910

UNDERTAKER: Not # Nine

ADDRESS ____

JUN 22 1936

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

Do not use this space.

19884

1. PLACE OF DEATH
County Dade — Registration District No. 479
Township Dadge — Primary Registration District No. 5618
City ... (No. ... St. ... Ward)

File No. ...
Registered No. ...

2. FULL NAME Geo Gage Rollins

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: Henrietta Arnett

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Apr 18 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	80	—	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ...

10. Date deceased last worked at this occupation (month and year) ... 11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

FATHER

13. NAME David Rollins

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Vermont

MOTHER

15. MAIDEN NAME Julia Rocker

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) L A Rollins Cookland Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE New Hope Cemetery DATE May 11 1936

19. UNDERTAKER (ADDRESS) Palmer & Lyon

20. FILED 5-11-1936 L A McComb Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 10. 1936

22. I HEREBY CERTIFY, That I attended deceased from May 10 1936, to May 10 1936

I last saw h... alive on ..., 19... Death is said to have occurred on the date stated above, at about 3 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	
c Myocardial Degeneration	

Other contributory causes of importance:

495

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) H. Summers Coffee, M. D.

(Address) Lebanon 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.

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

1 PLACE OF DEATH

County Laclede

Township Lebanon or Village or City (NO. St. Ward)

Registration District No. 449 File No. 6497

Primary Registration District No. 3609 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Julius Watson Scott

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June (Month) 23 (Day) 1863 (Year)

7 AGE: 53 yrs. 7 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Hamilton Kentucky

PARENTS

10 NAME OF FATHER: Franklin Scott

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia

12 MAIDEN NAME OF MOTHER: Lissie Bosley

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E Scott
(Address) Lebanon Mo.

15 Filed 2/17 1917 J M Ellis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 16 (Month) (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 14 1917 to Feb 16 1917, that I last saw him alive on Feb 16 1917, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease (1)
92A

(Duration) 23 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J H Casey M. D.
Feb 18 1917 (Address) Lebanon Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Neosho — DATE OF BURIAL: Feb 18 1917

20 UNDERTAKER: Richard Palmer — ADDRESS:

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

Do not use this space.

23383

File No. 1587

Registered No.

1. PLACE OF DEATH
County Oglede
Township Washington
City (No. St. Ward)
Registration District No. 449
Primary Registration District No. 5612

2. FULL NAME Mary E Scott

(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.

AUG 26 1930

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Or
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: J R Scott

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 22 Not Known

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
About	62	Not	Known	

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kent Va.

PARENTS

10. NAME OF FATHER: J H Campbell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kent Va.
12. MAIDEN NAME OF MOTHER: Elizabeth Gibson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Kent Va

14. INFORMANT: Dicky Palmer
(Address) Lebanon Mo

15. FILED 7/15/1930 J M Billingsley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 16 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1930 to July 16th, 1930 that I last saw h[illegible] alive on July 10th, 1930, and that death occurred, on the date stated above, at 5 [illegible] m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Interstial Pneumonia
Stomach
46 B

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Yes

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical

(Signed) J W Bailey, M. D.

, 19 (Address) Lebanon Mo

*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: New Hope — DATE OF BURIAL: 7/18 1930

20. UNDERTAKER: Palmer — ADDRESS: Lebanon

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

37283

1. PLACE OF DEATH
County Laclede — Registration District No. 449 — File No.
Township Washington — Primary Registration District No. 3692 — Registered No. 864
City (No. St. Ward)

2. FULL NAME Melvin Otis Scott

(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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	C	S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 8, 1911

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
10	5	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Laclede Co Mo

PARENTS

10. NAME OF FATHER Julius Scott
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Mary Campbell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)

14. INFORMANT Linwood Scott
(Address) Lebanon Mo

15. FILED 12/24 1920 J W Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 1920

17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1920, to Dec 23, 1920, that I last saw h... alive on Dec 23, 1920 and that death occurred, on the date stated above, at 8 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Nephritis
1 Yr
(duration) yrs. 5 mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Not known
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Urine Test + Physical Examination
(Signed) J W Billings M. D
, 19 (Address) Lebanon Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New Hope	Dec 25 1920
20. UNDERTAKER	ADDRESS
R A Solomon	Lebanon

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

31016

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.

1 PLACE OF DEATH

County Laclede

Township Washington or Village Rues or City (NO. St. Ward)

Registration District No. 4449 File No.

Primary Registration District No. 6312 Registered No. 422

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Roy Wayne Southard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Mar 2 (Month) (Day) 1911 (Year)

7 AGE: 4 yrs. 6 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Rues Mo

PARENTS

10 NAME OF FATHER: Frank M Southard

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Area Mo

12 MAIDEN NAME OF MOTHER: Rosa A Quinn

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Aklin Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank M Southard
(Address) Rues Mo

15 Filed Oct 10 1915 J M Kellerman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 24 (Month) (Day) 1915 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 9-20 1915 to 9-24 1915 that I last saw ~~him~~ alive on 9-24 1915 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

10 Pharangeal Diphtheria

(Duration) 04 yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J W Kinsey M. D.

9-24 1915 (Address) Orla Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mtn Hope Cemt

DATE OF BURIAL: 9-25 1915

20 UNDERTAKER: None

ADDRESS

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

1913

1 PLACE OF DEATH

County Laclede

Township Washington

or Village Rural

Registration District No. 449

Primary Registration District No. 6602

File No.

Registered No. 494

or City (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Anderson Southard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6 DATE OF BIRTH Dec 25th 1849 (Month) (Day) (Year)

7 AGE 65 yrs. — mos. 12 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer) V

9 BIRTHPLACE (City or town, State or foreign country) Middle Tennessee

PARENTS

10 NAME OF FATHER Alford Southard

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) V Tennessee

12 MAIDEN NAME OF MOTHER Mary Sparks

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) V Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J R Southard

(Address) Rural Mo

15 Filed 1/13, 1917 J M Billings Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 6th, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1-3, 1917, to 1-6, 1917, that I last saw h. alive on 1-5, 1917, and that death occurred, on the date stated above, at 8-30a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J W Lundeen M. D.

191 (Address) Arba Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 4 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Hope — DATE OF BURIAL Jan 7 - 1917

20 UNDERTAKER R Palmer — ADDRESS Lebanon

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.

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

1 PLACE OF DEATH

County Laclede

Township or Village Washington

Registration District No. 449

Primary Registration District No. 3612

File No. 13169

Registered No. 756

City (NO. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Inga June Southard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
	W	

6 DATE OF BIRTH: OCT 25 1844 (Month) (Day) (Year)

7 AGE: 73 yrs. 5 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

10 NAME OF FATHER: Joseph Haigh

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown

12 MAIDEN NAME OF MOTHER: Right

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosa Southard

(Address) Route No 4

15 Filed 3/8, 1920 J M Billings Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 15, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I saw deceased from 3-10, 1920, to, 191..., that I last saw her alive on 3-10, 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Unknown
Died Sudden
2 0 0 B

(Duration) 5 days yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J W Lindsay M. D.

3-17, 1920 (Address) Orla

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State 2 yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Hope Cemetery — DATE OF BURIAL: March 17, 1920

20 UNDERTAKER: No undertaker — ADDRESS

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.

No. 300
10.48

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

FILED JUL 10 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21026

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 115

1. PLACE OF DEATH
a. COUNTY: Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lebanon
c. LENGTH OF STAY (In this place): _____
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wallace Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Laclede
c. CITY OR TOWN: Lebanon
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒
e. STREET ADDRESS (If rural, give location): Plato Star Rt. R.D. 2500

3. NAME OF DECEASED (Type or Print): a. (First) James b. (Middle) Richard c. (Last) Southard

4. DATE OF DEATH: (Month) (Day) (Year) June 26 1956

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Aug. 24 1874
9. AGE (In years last birthday): 81 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (City and State or Foreign Country): Laclede Co. Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: J. A. Southard
13b. MOTHER'S MAIDEN NAME: Eliza J. Hough
14. NAME OF HUSBAND OR WIFE: Lillie Southard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): _____
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs. Gladys Hamilton 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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic pneumonitis (Unknown etiology) — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c) _____

II. 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: 492X
20. AUTOPSY? YES ☐ NO ☒

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) m.: _____
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? _____

22. *I hereby certify that I attended the deceased from* 4-24, 1956, *to* 6-26, 1956, *that I last saw the deceased alive on* 6-26, 1956, *and that death occurred at* 11.30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. H. Johnson (Degree or title): MD
23b. ADDRESS: Lebanon Mo
23c. DATE SIGNED: 6-28-56

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/29/56
24c. NAME OF CEMETERY OR CREMATORY: New Hope
24d. LOCATION (City, town, or county) (State): Laclede Co. Mo.

DATE REC'D BY LOCAL REG.: 6-29-1956
REGISTRAR'S SIGNATURE: Stella L. Hay
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: L. R. Palmer Lebanon Mo

(Licensed Embalmer's Statement on Reverse Side)

No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 15 1948
Registration District No. 3070

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Johnson 37212
State File No. 12-44-148
Primary Registration District No. 3023
Registrar's No. 167

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memeral Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 weeks (Specify whether years, months or days)
In this community 68 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Laclede 53
(c) City or town Rural (If outside city or town limits, write "RURAL") 0
(d) Street No. Plato Star Rt. (If rural, give location) 0
(e) Citizen of foreign country? NO. (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Dessdemonia Southard
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife J. R. Southard
6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Aug (Month) 25 (Day) 1880 (Year)

8. AGE: Years 68 | Months 3 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Cedar county (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business At home

MOTHER FATHER
12. Name James Brownlee G
13. Birthplace Cedar County (City, town, or county) Mo (State or foreign country)
14. Maiden name Minnie Walter. G
15. Birthplace unknown (City, town, or county) unknown (State or foreign country)

16. (a) Informant Mrs L L Hamilton
(b) Address Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/48 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope

18. (a) Signature of funeral director Palmer
(b) Address Lebanon, Mo.

19. (a) 12-5-48 (Date received by local registrar) (b) Trissie B. Lynch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3
year 1948 hour 6 minute 50 P.M.

21. I hereby certify that I attended the deceased from Oct 8, 1948 to Dec 3 1948; that I last saw her alive on Dec 3 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of retro peritoneal lymph nodes	3 yrs
Due to: Secondary to Carcinoma of uterus	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings of operations: Carcinoma involving retro-peritoneal lymph nodes and left ilium	
Autopsy	

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Terrell H Johnson (M. D. or other)
Address Lebanon Mo Date signed Dec 1948

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

No. 300
10.46

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 6 1956

State File No. 27458

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 142

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lebanon
c. LENGTH OF STAY (in this place) —
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wallace Memo. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Laclede
c. CITY OR TOWN Lebanon
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒
e. STREET ADDRESS (If rural, give location) Plato Star Rt. 0 S 3 2 0

3. NAME OF DECEASED (Type or Print) a. (First) Rosa b. (Middle) L c. (Last) Southard

4. DATE OF DEATH (Month) (Day) (Year) Aug. 22 1956

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
F	W	Married	Sept. 16 1876	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?
At Home	—	Laclede Co. Mo.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Joseph O'Quinn	Caroline Melton	Frank Southard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
No	—	—	Frank Southard	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.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility — 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) Rheumatoid arthritis — 25 yrs.
DUE TO (c)

II. 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?
	7220	YES ☐ NO ☒

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	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March, 1956, *to* Aug 22, 1956, *that I last saw the deceased alive on* Aug 21, 1956, *and that death occurred at* 3.30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
F. H Johnson	M D	Lebanon Mo	8-22-56

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/24/56	New Hope	Laclede Co. Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
8-24-1956	Ollella L. Hay	L. R. Palmer	Lebanon Mo

(Licensed Embalmer's Statement on Reverse Side)

424

S. No. 2
JM—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 21 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21750

Registration District No. 179 — Primary Registration District No. 5628 — Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Nebo (Rural Wasserman)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Nebo (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME JAMES LEORIS SOUTHARD
3. (b) If veteran, name war ✓
3. (c) Social Security No. None

4. Sex Male | 5. Color or race White | 6. (a) Single, widowed, married, or divorced Single
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased April (Month) 7 (Day) 1928 (Year)

8. AGE: Years 15 | Months 1 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Cherryvale Kansas (City, town, or county) (State or foreign country)
10. Usual occupation School boy
11. Industry or business .....

MOTHER FATHER
12. Name Unknown
13. Birthplace ..... (City, town, or county) ..... (State or foreign country) 9
14. Maiden name Effie Southard
15. Birthplace Laclede Co. (City, town, or county) Mo. (State or foreign country) 0

16. (a) Informant Effie Addison
(b) Address Lebanon Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope Cemetery
18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon Mo.
19. (a) May 31-43 (Date received by local registrar) (b) Grace Roper (Registrar's signature)

10-90

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1943 hour 4 0 minute 40 P.M.
21. I hereby certify that I attended the deceased from 2-3, 1943 to 5-18, 1943
that I last saw him alive on 5-13, 1943
and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death: Acute Endocarditis	9
Unspecified	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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

23. Signature R. E. Hamill (M. D. or other) MD
Address Lebanon Date signed 5-19-43

(Licensed Embalmer's Statement on Reverse Side)

U.S. No. 300
REV. 10-48

FILED MAR 5 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4518

State File No. 2000

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. _____ Registrar's No. 191

0396

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Springfield
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Springfield Baptist Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Laclede
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lebanon 0532
d. STREET ADDRESS (If rural, give location) Unknown 1

3. NAME OF DECEASED (Type or Print) a. (First) alfred b. (Middle) – c. (Last) Southard

4. DATE OF DEATH (Month) Feb (Day) 27 (Year) 1951

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan 7 1869

9. AGE (If under 1 year or 1 day old) Last birthday) 82 Years | If under 1 year Months 1 | Days 18 | If under 24 hrs. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY FARM

11. BIRTHPLACE (State or foreign country) Lebanon Mo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Felix A Southard

13b. MOTHER'S MAIDEN NAME Eliza J Haught

14. NAME OF HUSBAND OR WIFE Bell Southard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Alvia Southard 2156 W Walnut Springfield 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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adeno Carcinoma Primary of Liver with metastasis to Sigmoid

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

INTERVAL BETWEEN ONSET AND DEATH 2 1564

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Sliding Hernia of Sig moid Lt Inguinal

19a. DATE OF OPERATION 2-16-51

19b. MAJOR FINDINGS OF OPERATION Repair Lt inguinal hernia Biopsy findings Adeno Carcinoma of Sigmoid

20. AUTOPSY? YES ☐ NO ☑

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) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-9-, 1957, to 2-25, 1957, that I last saw the deceased alive on 2-25-, 1957, and that death occurred at 8:15 a m., from the causes and on the date stated above.

23a. SIGNATURE C E Feller (Degree or title) MD

23b. ADDRESS 609 Cherry Springfield

23c. DATE SIGNED 2-26-51

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 2/27/51

24c. NAME OF CEMETERY OR CREMATORY New Hope

24d. LOCATION (City, town or county) Laclede Co (State) Mo

DATE REC'D BY LOCAL REG. 3-2-51

REGISTRAR'S SIGNATURE W E Handley MD

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Holman Funeral Home Lebanon Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE 4 PERMANENT RECORD

s. No. 300
d—10-47
r. 5-17-39
Ed I 3908

53
1
2

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 12 1948
Registration District No. 170

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. ~~170~~ 3033

State File No. 33398 11-48-122

Registrar's No. 125

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days (Specify whether
In this community 2 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede
(c) City or town Lebanon Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Plato Route
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Jane Stovall
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lee Stovall
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased Jan. (Month) 30 (Day) 1894 (Year)

8. AGE: Years 54 | Months 8 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Laclede Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Francis M. Roberts
13. Birthplace Vandalia Ill. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Samantha Southard
15. Birthplace Laclede Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Lee Stovall
(b) Address Lebanon Plato Rt.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-48 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope Cemetery
18. (a) Signature of funeral director W. E. Holiman
(b) Address Lebanon Mo.
19. (a) 11-1-48 (Date received local registrar) (b) Truman B. Lynch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29
year 1948 hour 2 minute 40 A.M.
21. I hereby certify that I attended the deceased from 30 Sept, 1948, to 29 Oct, 1948;
that I last saw him alive on 28 Oct 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Embolus	14 hrs.
Due to: Hypertension	10 Yrs.
Due to: [illegible]	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: Fibroid Uterus 30 Retroversion.	PHYSICIAN — Underline the cause to which death should be charged statistically.
Of autopsy: None.	

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

23. Signature Paul A. Jenkins M.D. (M. D. or other)
Address Lebanon Mo. Date signed 29 Oct 48.

11-1-48

(Licensed Embalmer's Statement on Reverse Side)

MAY 22 1933

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space. 12965

1. PLACE OF DEATH
County Greene Registration District No. 3,8 File No.
Township Spgfd Primary Registration District No. 2001 Registered No. 363
City Spgfd (No. 814, Franklin St. Ward)

2. FULL NAME Isaac Dennis Thomas

(a) Residence, No. 814 - Franklin 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 Male
4. COLOR OR RACE Col.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 7 1888
7. AGE Years 44 Months 10 Days 22 If LESS than 1 day, ...hrs. or ...min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Spgfd Mo

FATHER
13. NAME J. W. Thomas
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Mo

MOTHER
15. MAIDEN NAME Margaret Burns
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) East Tennessee

17. INFORMANT Mrs. Margaret Thomas
(ADDRESS) 814 - Weaver

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hazlewood DATE May 2 1933

19. UNDERTAKER H. V. Smith
(ADDRESS) 421 - E. Pine

20. FILED 5 - 1 1933 Ralph W Tangs Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 29 - 1933

22. I HEREBY CERTIFY, That I attended deceased from April 29, 1933, to April 29, 1933

I last saw h... alive on ..., 19... Death is said to have occurred on the date stated above, at 9.30 ...m.

The principal cause of death and related causes of importance were as follows: Date of onset

23B
23B(?) Pulmonary Hemorrhage
23

Other contributory causes of importance:

Tuberculosis of lung

Name of operation ... Date of ...
What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) James B. Clark, M. D.
(Address) 601 N. Jefferson

Clark
Williams
Hunter

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.

PLACE OF DEATH

County Laclede

Township Washington or Village Rural or City ____ (No. ____ St.; ____ Ward)

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

39262

Registration District No. 449 File No. ____

Primary Registration District No. 5612 Registered No. 252

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Anna E Tyree

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	widow

DATE OF BIRTH: Jan 6 (Month) 6 (Day) 1823 (Year)

AGE: 91 yrs. 8 mos. 18 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Clay Co Ill 162

PARENTS

NAME OF FATHER: John Stripling

BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn.

MAIDEN NAME OF MOTHER: Minnett Inman

BIRTHPLACE OF MOTHER (City or town, State or foreign country): ____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Tyree

(ADDRESS) Russ Mo

Filed Dec 8, 1914 J M Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept 25 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept, 1913, to Sept 25, 1914, that I last saw h[e] alive on about Sept 20, 1914, and that death occurred, on the date stated above, at ____ m. do Not Heard

The CAUSE OF DEATH* was as follows:

Fractured Femur
Senile Debility

(Duration) 1 yrs. ____ mos. ____ ds.

Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J M Lindsay M. D.

10/10 1914 (Address) Elgin Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Mt. Hope — DATE OF BURIAL: 9-26 1914

UNDERTAKER: Ross Hackman — ADDRESS: Lebanon

S. No. 2
M—5-43
. 5-17-39
b I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1947

Registration District No. 140

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5630

State File No. 17949

Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town RURAL LEBANON TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
LEBANON R.I. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution — (Specify whether
In this community ALWAYS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County LACLEDE 53
(c) City or town RURAL 0
(If outside city or town limits, write "RURAL")
(d) Street No. R.I. LEBANON 0
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME ARTHUR WALLACE

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased SEPT. (Month) 1 (Day) 1873 (Year)

8. AGE: Years 73 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace LACLEDE Co. (City, town, or county) MO (State or foreign country) 0

10. Usual occupation FARMER

11. Industry or business

FATHER
12. Name J. K. WALLACE
13. Birthplace (City, town, or county) KY (State or foreign country)

MOTHER
14. Maiden name EMILY E. ROBERTSON
15. Birthplace LACLEDE Co. (City, town, or county) MO (State or foreign country) 0

16. (a) Informant Madison Devasure
(b) Address Lebanon Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-47 (Month) (Day) (Year)
(c) Place: burial or cremation NEW HOPE CEM.

18. (a) Signature of funeral director PALMER S
(b) Address LEBANON MO

19. (a) May 10, 1947 (Date received local registrar) (b) Reg Frankenberger (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 5
year 1947 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from Apr. 1, 1947 to 5-May 1947
that I last saw him alive on 5-May 1947
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypertensive Heart Disease	
Due to Chronic myocarditis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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

23. Signature J. Summers (M. D. or other) M.D.
Address Lebanon Mo Date signed 5-6-47

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

PLACE OF DEATH

County Laclede

Township Lebanon or Village or City ____ (NO. ____ St. ____ Ward)

Registration District No. 449 File No. 23115

Primary Registration District No. 5609 Registered No. 301

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John Kindrick Wallace

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

DATE OF BIRTH: March (Month) 27 (Day) 1831 (Year)

AGE: 73 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming

BIRTHPLACE (City or town, State or foreign country): Kentuckey

PARENTS
NAME OF FATHER: I. Wallace
BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn.
MAIDEN NAME OF MOTHER: Kirkpatrick Laughlin
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. A. Palmer.

(ADDRESS) Lebanon Mo.

Filed July 6. 1914. J. W. Bennett REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 27 (Day) 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 10 —, 1914, to May 25, 1914, that I last saw h[illegible] alive on May 25 —, 1914, don't Know. and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Infection from Urinary torch. due to Enlarged Prostate Gland

90 (Duration) Chronic mo. ____ ds.

Contributory (SECONDARY) Chronic Bronchitis (Duration) Don't Know ds.

(Signed) F. D. Herbert M. D.

May 28. 1914 (Address) Lebanon, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Hope Laclede Co.	May 28TH. 1914
UNDERTAKER	**ADDRESS**
R. A. Palmer.	Lebanon Mo.

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

Do not use this space.

28688

File No.

Registered No.

1. PLACE OF DEATH
County Laclede Registration District No. 96-2
Township Franklin Primary Registration District No. 3617
City (No. St. Ward)

2. FULL NAME Nathaniel J. Webb

(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.

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.

SEP 22 1931

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Mrs. B. Edwards

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 10 - 1857

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
74	1	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Baron Co Kentucky

FATHER

13. NAME William Henry Webb

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER

15. MAIDEN NAME Ebby Craton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT William Webb
(ADDRESS) Competition Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Marshall Cemetery DATE aug 24 1931

19. UNDERTAKER Hobson & Hearst
(ADDRESS) Lebanon Mo.

20. FILED aug 9 1931 Isabelle Lewis Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 23 1931

22. I HEREBY CERTIFY, That I attended deceased from aug 10 1931, to aug 10 1931

I last saw h[illegible] alive on aug 10 1931. Death is said to have occurred on the date stated above, at 9-50 a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemmorhage	aug 16

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) P. Thompson, M. D.
(Address) Lebanon Mo.