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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED 18:10

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32392

Registration District No. 465

Primary Registration District No. 4278

Registrar's No. 13

1. PLACE OF DEATH: Lafayette  
 (a) County: Lafayette  
 (b) City or town: Waverly  
 (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 2  
 (Specify whether  
 In this community  
 years, months or days)

3. (a) PRINT FULL NAME: Ida H. Daugherty  
 (b) If veteran, name war: No  
 (c) Social Security No.:

4. Sex: F  
 5. Color or race: W  
 6. (a) Single, widowed, married, divorced: Widowed  
 (b) Name of husband or wife: J. J. Daugherty  
 (c) Age of husband or wife if alive: 31 years  
 7. Birth date of deceased: 5/31/1868  
 (Month) (Day) (Year)

8. AGE: Years: 76 Months: 3 Days: 20  
 If less than one day: hr. min.

9. Birthplace: Illinois  
 (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

12. Name: James Hackett

13. Birthplace: Ill  
 (City, town, or county) (State or foreign country)

14. Maiden name: Agnes Crowder

15. Birthplace: Tenn  
 (City, town, or county) (State or foreign country)

16. (a) Informant: Ephraim Mobley

(b) Address: Waverly Mo

17. (a) Burial (b) Date thereof: 9-23-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Union Cem. Maets Bau

18. (a) Signature of funeral director: Willis Marshall

(b) Address: 600 S. Main St, Mo

19. (a) 9-22-40 (b) Clayton H. Sandrum  
 (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 21  
 year 1940 hour 2 minute 50 P. M.

21. I hereby certify that I attended the deceased from 9-21-40  
 on 9-21-40 to 19:00

that I last saw her alive on 9-21-40 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Pneumonia

Due to: Senility

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy:

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: 3

23. Signature: [Signature] (M. D. or Other) Date signed: 9-21-40

Address: Waverly

Date signed: 9-21-40

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

MOTHER FATHER

1118

RECEIVED  
District Health Officer No. 8  
District File Number 10-8-40  
Date Filed

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

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

Signed J. E. Willis

Licensed Embalmer No. 1783

P. O. Address Canaan mo.

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

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **32392**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **465**

Primary Registration District No. **4278**

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County **Lafayette**  
(b) City or town **Lawrence**  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or \_\_\_\_\_ (Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Ida H. Daugherty**

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 **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **76** Months **3** Days **20** If less than one day \_\_\_\_\_ min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

20. DATE OF DEATH Month **9** day **21** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_ that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death **Supostate pneumonia (Bronch)**

Due to **senility**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **107N**

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature **Geo F Jones** (M. D. or other)

Address **Lawrence Mo** Date signed \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

