No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38806

Registration District No. 3-55 3-47

Primary Registration District No. 549-8-3018

Registrar's No. 21

FILED DEC 7 1940

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

1. PLACE OF DEATH:

(a) County Henry

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

(c) Name of hospital or institution: Clinton General Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community 69 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry

(c) City or town Rural (If outside city or town limits, write "RURAL") Walker twp

(d) Street No. near Montrose (If rural, give location)

0

(e) If foreign born, how long in U. S. A.? ____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4

year 1940 hour 8 minute 5 P. M.

21. I hereby certify that I attended the deceased from Aug 8, 1940, to Oct 4, 1940; that I last saw him alive on Oct. 4, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial degeneration	6 mo.
Due to:	
Due to:	
Other conditions: Ch. bronchitis (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 W. E. Baggarly (M. D., or other) MD

Address Montrose Mo Date signed 10-7-40

8. (a) PRINT FULL NAME John Robert Lobaugh

8. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bettie

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased June (Month) 27 (Day) 1871 (Year)

8. AGE: Years 69 | Months 3 | Days 7 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Farmer

11. Industry or business own farm

MOTHER FATHER

12. Name Jacob G. Lobaugh

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

14. Maiden name Rachel Mybaugh

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

16. (a) Informant Elmer Lobaugh

(b) Address Arma Calif

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Stone Chapel Cemetery

18. (a) Signature of funeral director Fenwick & Leonard

(b) Address Montrose Mo

19. (a) 10-7-40 (Date received local registrar) (b) W. E. Baggarly (Registrar's signature)

312

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 11-40-1565
Date Filed 11-6-40

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.....
October 4th 1940, Registered Apprentice No.....
working under my personal supervision.

Signed Oscar Eckhoff

Licensed Embalmer No. 3942

P. O. Address Upton City Iowa

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

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 347 Primary Registration District No. 3018 Registrar's No. 21

FILED DEC 14 1940

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

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: died at Clinton Gen. Hosp (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 (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 John Robert Lobaugh
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 M
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 69 Months 3 Days 7 If less than one day hr. 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)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 12-11-40 (Date received local registrar) (b) Wm. J. P. Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4 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 , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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 W. E. Bayerly (M. D. or other)
Address Montrose Mo Date signed

SUPPLEMENTARY

S-38806 1940