

FILED APR 21 1941

Registration District No. **449**

Primary Registration District No. **4267**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Euclid
(b) City or town Lubaron
(c) Name of hospital or institution: Wallace
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution few hours (Specify whether) 0
In this community none years, months or days

3. (a) PRINT FULL NAME

Peter A. Dell

3. (b) If veteran, name war World War

3. (c) Social Security No. 337-10-4951

4. Sex m race w

5. Color or

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

6. (b) Name of husband or wife Mar Dell

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Nov (Month)

1895 (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>45</u>	<u>3</u>	<u>3</u>	hr. _____ min.

9. Birthplace

Web. (City, town, or county) (State or foreign country)

10. Usual occupation

Mechanic

11. Industry or business

12. Name Pa Dell

13. Birthplace

W.K. (City, town, or county) (State or foreign country)

14. Maiden name

Melvine Vosh

15. Birthplace

W.K. (City, town, or county) (State or foreign country)

16. (a) Informant

Mar Dell

(b) Address

St James

17. (a) Edyville (Burial, cremation, or removal)

(b) Date thereof 3 21-41 (Month) (Day) (Year)

(c) Place: burial or cremation

Low Clark

18. (a) Signature of funeral director

Rolla 404

(b) Address

19. (a) 3-70-41 (Date received local registrar)

(b) J. M. Carr (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Euclid
(c) City or town Lubaron (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 Mch day 19
year 1941 hour 3 minute 30 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.

Immediate cause of death

Crushed pelvis

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) a railroad
(b) Date of occurrence 3-19-1941
(c) Where did injury occur? Post Wood (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Camp construction

While at work? yes (Specify type of place) farm over by (e) Means of injury fall

23. Signature J. M. Carr (M.D. or other) 3-30-41
Address Lubaron Mo Date signed 3-30-41

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

MOTHER FATHER

RECEIVED
District. ~~File~~ Officer No. 7,
District. ~~File~~ Number 44-1110
Date Filed 4/16/44

STATEMENT BY LICENSED EMBALMER

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

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

Registration District No. 449

Primary Registration District No. 4267

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:
 (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)

3. (a) PRINT FULL NAME

Peter A. Nell

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 NOT KNOWN

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	Months	Days
<u>45</u>	<u>3</u>	<u>3</u>

If less than one day

9. Birthplace _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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 _____

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
 that I last saw him _____ on _____
 and that death occurred on the date and hour stated above.
 Immediate cause of death: _____
 Duration _____

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? _____

While at work? _____ (Specify type of place)
 (a) Means of injury _____
 23. Signature James D. Stanton (M. D. or other) _____
 Address Lebanon Mo. Date signed _____

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

1941
S-11126

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

This Prescription to be Filled only by a Registered or Graduated Pharmacist

Date.....

R

For Age.....

This man was a worker
at Ft Wood and within
the company, who signed the
certificate nor the
undertaker has any
record of his family.

J. A. McCombs

TAKE THIS TO
SIDNEY'S
CUT RATE
DRUG STORE
PHONE 27
LEBANON, MO.

M. D.