

ED JUL 23 1941

474

Primary Registration District No.

5638

Registrar's No.

1. PLACE OF DEATH:

(a) County: Lawrence
(b) City or town: Eureka Mo. R. 2
(c) Name of hospital or institution: L

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 6 years (Specify whether years, months or days)

In this community: Six years (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Lucretia F. Lloyd

3. (b) If veteran, name war: L 3. (c) Social Security No. L

4. Sex: Female 5. Color or race: white 6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Frank F. Lloyd 6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: 41-2-1891 (Month) (Day) (Year)

8. AGE: Years 50 Months 1 Days 15 If less than one day hr. min.

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

10. Usual occupation: Housewife

11. Industry or business:

12. Name: Joines Wolff

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

14. Maiden name: Atkinson Clark

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

16. (a) Informant: Mr. Frank F. Lloyd

(b) Address: Eureka Mo. R. 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-17-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Dandell

18. (a) Signature of funeral director: Norma Deimon

(b) Address: Miller Mo.

19. (a) 7/1-1941 (b) Mrs. Anna Wilkerson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Lawrence
(c) City or town: Eureka Mo. R. 2
(d) Street No. 2

(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15 year 1941 hour 12 minute 20 P. M.

21. I hereby certify that I attended the deceased from MAY 10 1941 to June 15 1941; that I last saw her alive on June 7 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Nephritis (acute) with aneurysm

Due to:

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?

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

23. Signature: L. J. Dolmus (M. D. or other)

Address: Miller, Mo. Date signed: 6-16-41

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

MOTHER FATHER

130

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 J. R. Leinen

Licensed Embalmer No. 3297

P. O. Address Miller 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22062

Registration District No. 474

Primary Registration District No. 5638

Registrar's No. _____

1. PLACE OF DEATH: Lawrence

(a) County _____

(b) City or town _____
(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 Lucretia Floyd

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years _____ months _____ days

7. Birth date of deceased: Apr. 2 1891
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one year _____ 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)

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 _____

20. DATE OF DEATH: Month June day 15
year 1947 hour _____ minute _____ M.

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

Immediate cause of death: nephritis acute with anacarcia
Due to: Cold, Influenza
did not follow chronic

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 _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

mother, the

