

FILED APR 9 1945
Registration District No. 174

Primary Registration District No. 3035

State File No. _____
Registrar's No. 14

1. PLACE OF DEATH:

(a) County Lopprette
(b) City or town Luxington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 621 Highland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 60 yrs years, months or days

3. (a) PRINT FULL NAME DORA D DORAN

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

4. Sex Fe / 5. Color or race W. 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Jan. 26 1856
(Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

MOTHER FATHER

12. Name Wessel J
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name not known
15. Birthplace "
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Rover
(b) Address 621 Highland, Luxington

17. (a) Burial (b) Date thereof 3-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Luxington, Mo

18. (a) Signature of funeral director Garrick J. Kumpel
(b) Address Luxington, Mo

19. (a) April 4-45 (b) Mrs F. Schwal
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lopprette
(c) City or town Luxington 54
(If outside city or town limits, write "RURAL")
(d) Street No. 621 Highland 3
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 21
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 28
year 1945 hour 11 minute A M.

21. I hereby certify that I attended the deceased from Mar 27 1945 to Mar 28 1945
that I last saw hw alive on Mar 28 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Esophagus Duration _____

Due to Internal disease - Esophagus SUPPLEMENTARY INFORMATION REQUESTED
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? _____

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

23. Signature [Signature] (M. D. or other) _____
Address Luxington Mo Date signed 3/28/45

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

RECEIVED

District Health Officer No. 8,

District File Number

4/6/45

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. L. McKean

Licensed Embalmer No. 2983

P. O. Address Levington, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 14

Registration District No. 114 Primary Registration District No. 3035

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

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lexington
(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 Dora D. Doran

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 W

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

7. Birth date of deceased Jan 26 1898
(Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days _____ If less than one day
hr. min.

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 21 year 1945 hour _____ minute _____ M.

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

Due to Chronic Myocarditis Duration several years

Due to _____

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

(c) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Date signed 11/21/45

SUPPLEMENTARY

10022