CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

OCT 25 1927

Do not use this space.

26848

1. PLACE OF DEATH

County Crawford — Registration District No. 233 — File No.

Township Liberty — Primary Registration District No. 5318 — Registered No. 195

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Tillie I Dyckman

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ ~~(OR)~~ WIFE OF Barney H Dyckman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22 - 1858

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
68	10	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER M. Camp

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

14. INFORMANT Barney H Dyckman
(Address) Bourbon Mo

15. ~~FILED~~ Sept 27 1927 W. F. Irwin M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 26, 1927

17. I HEREBY CERTIFY, That I attended deceased from 9 25, 1927, to 9 26, 1927 that I last saw her alive on 9 - 25, 1927, and that death occurred, on the date stated above, at 8 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) Not Known

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? —

IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) E. L. Hume, M. D

, 19 (Address) Bourbon, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Missouri Crematory — DATE OF BURIAL 1 19

20. UNDERTAKER St Louis Mo — ADDRESS Bourbon Mo

F H Linstromberg

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Crawford — Registration District No. 233 — File No.

Township Liberty — Primary Registration District No. 5-318 — Registered No. 195

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Tillie I Dyckman

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED Sept 27, 19 27 W. F. Drum MD. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 26 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Missouri Crematory	19
20. UNDERTAKER St. Louis Mo F. W. Linstromberg	ADDRESS Bourbon Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

... should be stated EXACTLY. PHYSICIANS ... in plain terms, so that it may be prop... classified. Exact statement of OCCUPATION is very impor...

[illegible]-5