

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

Do not use this space.

Amitt. ULL 22 1930
PLACE OF DEATH
County *Humboldt*
Township *Holcomb*
City (No.) (St.) (Ward)

Registration District No. *284*
Primary Registration District No. *5404*

File No. *35770*
Registered No.
St. Ward

2. FULL NAME *D. D. Dye*
(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 *M*
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 *Jessie Harris Dye*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov-13-1869*
7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min. *60 11*
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Farmer*
(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) *Tennessee*
10. NAME OF FATHER *Not known*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Not known*
12. MAIDEN NAME (CITY OR TOWN) (STATE OR COUNTRY) *Mary Jane Baker*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Holcomb Tennessee*

14. INFORMANT *D. D. Dye Jr.*
(Address) *Cape Girardeau, Mo*

15. FILED 19... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov-6 1930*
17. I HEREBY CERTIFY, That I attended deceased from *11-4 1930* to *11-6 1930* that I last saw him alive on *11-6 1930* and that death occurred, on the date stated above, at *1-9* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH...
DID AN OPERATION PRECEDE DEATH? DATE OF...
WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS *none*
(Signed) *H. T. Smith*, M. D.
11-7 1930 (Address) *Holcomb 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 *Pine City* DATE OF BURIAL *11/7 1930*

20. UNDERTAKER *Baldwin Wood & Kenneth* ADDRESS *Mo*

N. B.—Every CAUSE OF DEATH in plain terms, so that it may be properly classified.

**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 Franklin Registration District No. 286 File No.
Township Holcomb Primary Registration District No. 3404 Registered No.
City (No.) St. Ward

2. FULL NAME

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 13 - 1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 50

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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)

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 12-10-1930 J. A. Anderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 6 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PH. should be stated EXACTLY. Cause of Death should be stated EXACTLY. Department of Occurrence should be stated EXACTLY.

RECORDED BY LAW

FEE FOR COPY

REGISTRARS SH

SUPPLEMENTARY

5-35770