

Cochran

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

Do not use this space.

19042

1. PLACE OF DEATH

County Dunklin Registration District No. 289
 Township Holcomb Primary Registration District No. 404
 City (No. _____) St. _____ Ward _____

2. FULL NAME

Riley Thomas 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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dola
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 28 1889
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 1 3

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dunklin Co Mo.

MOTHER FATHER
 13. NAME Jim Dye

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER FATHER
 15. MAIDEN NAME Murlie Francis Mason

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Pine City DATE 5-2-36

19. UNDERTAKER (ADDRESS) W. J. Dyer

20. FILED 6-10-36 1936 W. J. Dyer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-1 1936

22. I HEREBY CERTIFY, That I attended deceased from 4/30 to 4/30
 I last saw him alive on 4/30 Death is said to have occurred on the date stated above, at 5:15A
 The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia Date of onset unknown

Other contributory causes of importance:
Pulmonary Tuberculosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? Lob Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____ (Signed) Wm Cochran, M. D.
 (Address) Holcomb

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

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