

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

17425  
Do not use this space.

JUN 9 1938

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Jean Primary Registration District No. 1002  
 (c) City Kennett (d) Street No. 1017 E. 22nd Registered No. 2122  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah E. Dyke 200  
 (a) Residence, No. 1018 E. 22nd St. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-22-1884

7. AGE YEARS 54 MONTHS 3 DAYS 28 If LESS than 1 day, ..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-20 1938

22. I HEREBY CERTIFY, That I attended deceased from 5-15 1938 to 5-20 1938  
 I last saw him alive on 5-18 1938. Death is said to have occurred on the date stated above, at 8:45 PM  
 The principal cause of death and related causes of importance were as follows:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ma

Arteriosclerotic  
Heart Disease  
Senility

Date of onset

Other contributory causes of importance:

FATHER 13. NAME John Wright

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ma

MOTHER 15. MAIDEN NAME Sarah Robinson

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ma

17. INFORMANT (ADDRESS) Mrs. Grace D. Ernst  
1017 E. 22nd St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Wash. Cem. DATE 5-24 1938

19. FUNERAL DIRECTOR (ADDRESS) Burt Henderson  
154 Jackson

20. FILED May 23, 1938  
M. Brown  
 Local Registrar.

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? no

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) P. F. De Marna M. D.  
 (Address) Supt. K. C. Gen. Hospital

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.

**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**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.)**