REC'D JUL 22 1938

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

22360
Do not use this space.

DEATH
Macon
Registration District No. 534
Township
Primary Registration District No. 4319
Registered No. 5
(c) City New Cambria (d) Street No. St.
(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 Norma Jean Dennis 520
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 7 - 1937
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

OCCUPATION
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 —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Cambria Mo

FATHER
13. NAME John H. Dennis
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Co Mo

MOTHER
15. MAIDEN NAME Eunice Velma Miller
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chariton Co Mo

INFORMANT (ADDRESS) John H. Dennis New Cambria Mo
BURIAL, CREMATION, OR REMOVAL
PLACE Johnson Cem DATE May 21 1938
FUNERAL DIRECTOR (NAME) (ADDRESS) Howard Gilleland New Cambria Mo
FILED July 8 1938 O.D. West
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from May 15, 1938 to May 20th, 1938
I last saw her alive on May 20, 1938 Death is said to have occurred on the date stated above, at 1:15 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Inflamation of Tomas	May 17 1938
115	
Other contributory causes of importance: Teething	Apr 1 1938

Name of operation None Date of —
What test confirmed diagnosis? Clinical 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? No
If so, specify —
(Signed) O.D. West, M. D.
(Address) New Cambria Mo

(Licensed Embalmer's Statement on Reverse Side)

EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important.

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, ...
H. J. Gilleland, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed H. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Faile with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

22360
Do not use this space.

1. PLACE OF DEATH
(a) County Macon — Registration District No. 334
(b) Township — Primary Registration District No. 4319 — Registered No. 5
(c) City New Cambria (d) Street No. ..... St.
(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 Norma Jean Dennis
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 7 1937

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
0	8	13	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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

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

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

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

19. FUNERAL DIRECTOR (ADDRESS)

FILED June 8, 1938 C. O. West Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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) C. O. West, M. D.
(Address) New Cambria Mo

SUPPLEMENTARY