

REC'D JUN 14 1939

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

20075
Do not use this space.

1. PLACE OF DEATH

(a) County Wayne Registration District No. 840
(b) Township St. Francois Primary Registration District No. 6188
(c) City (d) Street No. Registered No.
(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.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

407 Johnnie Gyander Hale
(a) Residence, No. 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

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infante

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar-24-1938

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. WPA
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) Wayne Co Mo

FATHER 13. NAME Gyander Hale

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

MOTHER 15. MAIDEN NAME Floa Martin

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

17. INFORMANT (ADDRESS) Gyander Hale

18. BURIAL, CREMATION, OR REMOVAL PLACE Nicholson Cemetery DATE Mar-27-1939

19. FUNERAL DIRECTOR (ADDRESS) NONE

20. FILED May 31st 1939 Mabel Beasley Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 26, 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:

Strangulation

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) J. A. Myers, M. D.

717 (Address) Greenwell Mo!

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.)