

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.

1939 SEP 19 1939

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

29056
Do not use this space.

1. PLACE OF DEATH
 (a) County Dunklin Registration District No. 286
 (b) Township Halecomb Primary Registration District No. 5404 B Registered No. _____
 (c) City Halecomb (d) Street No. _____ (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 W. Guy Dye
 (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 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 Dorothy Dye

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 11, 1980

7. AGE YEARS 59 MONTHS 4 DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.

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. Farmer
 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) Providence Kentucky

FATHER
 13. NAME Johnson Dye
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Providence Kentucky

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

17. INFORMANT Wife Clark (ADDRESS) Halecomb

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Home City DATE 8-13

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Raymond Russell
Criggett Ark.

20. FILED Sept 9 19 39 J. C. Anderson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 12 1939

22. I HEREBY CERTIFY That I attended deceased from Aug 9th to Aug 12 1939
 I last saw him alive on Aug 12th 1939. Death is said to have occurred on the date stated above, at 5 P. m.
 The principal cause of death and related causes of importance were as follows:
Coronary Arteriosclerosis
 Date of onset Jan 6 39

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? None 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) John G. DeLoach M. D.
Halecomb (Address)

RECEIVED

District Health Officer No. 3,

District File Number 939-57

Date Filed 9/13/39

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,

....., or by

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

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