

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

33128
 Do not use this space.

OCT 13 1939

1. PLACE OF DEATH *2*

(a) County *Cuyler* Registration District No. *632*
 (b) Township *Hayes* Primary Registration District No. *4382*
 (c) City *Hayes* (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 *250 Lester Dasher*

(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 *Fe* 4. COLOR OR RACE *Wh* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Infant*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 4 - 1939*

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

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

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) *Hayes Mo.*

FATHER 13. NAME *Lester Dasher*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Director Ill*

MOTHER 15. MAIDEN NAME *Therese Martineau*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Fall River Mass.*

17. INFORMANT (ADDRESS) *Mrs. Yvonne Dasher Hayes*

18. BURIAL, CREMATION, OR REMOVAL PLACE *New Lebanon* DATE *Sept 6 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Leo Carr Hayes*

20. FILED *Sept 5 1939* *George Johnson* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 5 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 4* 19*39* to *Sept 5* 19*39*
 I last saw h. *ex* alive on *Sept 5* 19*39*. Death is said to have occurred on the date stated above, at *6:00* p.m.
 The principal cause of death and related causes of importance were as follows:

Premature Birth

Date of onset _____

Other contributory causes of importance: *154*

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. [Signature]* M. D.
 (Address) _____

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 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.....

RECEIVED
working under my personal supervision.

District Health Officer No. 5,

District File Number 1039310

Date Filed 10/10/29

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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