

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEC 21 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39458

State File No. _____

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Daviess
 (b) City or town "Rural" Jackson Township
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 22 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess
 (c) City or town "Rural" Jackson Township
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME Elnora Susan VanDyke 532

3. (b) If veteran, name war XX 3. (c) Social Security No. XX

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife William VanDyke 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased March 18 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 7 29 hr. _____ min.

9. Birthplace Xenia Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business Same

12. Name George W. Fletcher

13. Birthplace Unknown Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Clara Crites

15. Birthplace Unknown West Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clara Van Dyke

(b) Address Gallatin, Mo.

17. (a) Burial (b) Date thereof 11-19-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lock Springs, Mo.

18. (a) Signature of funeral director Hope Turn. & Death Co.

(b) Address Gallatin Missouri

19. (a) Nov 18 (b) Ed J. Minnick
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17
 year 1939 hour 7 minute 55 A. M.

21. I hereby certify that I attended the deceased from Jan. 12, 1939, to Nov. 17, 1939;
 that I last saw her alive on Nov. 16, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Permeable Anemia *D. J. P.*

Due to _____

Due to _____ *n/w*

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature P. R. Doolin (M. D. or other) _____

Address Gallatin Mo. Date signed 11-18-39

RECEIVED

District of Columbia No. 163

Case No. 1239-1747

File No. DEC 16 1939

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

L. O. Richesson

Licensed Embalmer No.

3302

P. O. Address

Gallatin, Mo.

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.