

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40051
Registrar's No. 60

Registration District No. 441 Primary Registration District No. 4259

1. PLACE OF DEATH:
(a) County Knox
(b) City or town Edina
(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)
In this community 50 years, months or days

3. (a) PRINT FULL NAME John Dorian
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M. 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mary Weishar
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 30, 1867
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Charles Dorian
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Du Larey
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address _____

17. (a) Edina, Mo. (b) Date thereof Nov 12 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Catholic Cemetary.

18. (a) Signature of funeral director Keith Hudson
(b) Address Edina Mo

19. (a) Nov 12 1939 (b) Mrs C. M. Smith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Knox
(c) City or town Edina
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9
year 1939 hour 6 minute _____ A. M.
21. I hereby certify that I attended the deceased from Nov. 9, 1939 to Nov 9, 1939
that I last saw him alive on Nov. 9, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis Duquoin Short
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy no
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 E. S. Luman (M. D. or other) _____
Address Edina Mo Date signed 11/13/39

RECEIVED

District Health Officer No. 10

District File Number 12-39-2035

Date Filed DEC 5 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 Reuben Luskison

Licensed Embalmer No. 2415

P. O. Address Edina, Minn.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

400571
Do not use this space.

1. PLACE OF DEATH

(a) County Knox Registration District No. 441

(b) Township Primary Registration District No. 4259 Registered No. 60

(c) City Edina (d) Street No. St.

(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 John Dorian

(a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 30 - 1867

7. AGE YEARS 72 MONTHS 2 DAYS 9 If LESS than 1 day, hrs. or min.

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 16 19 40 Mrs C.M. Smith Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 9 19 39

22. I HEREBY CERTIFY, That I attended deceased from _____ 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) F.E. Human M. D.
(Address) Edina Mo

SUPPLEMENTARY

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