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 12 1939

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

40278
Do not use this space.

1. PLACE OF DEATH
(a) County Mississippi 2 Registration District No. 566
(b) Township ~~Tywappity~~ Ohio 1 Primary Registration District No. 5762 Registered No. 115
(c) City ~~Charleston~~ (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 500 Betty Sue Dean
(a) Residence, No. Charleston, Mo R#2 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Infant
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 11/3/39
7. AGE: YEARS 0 MONTHS 0 DAYS 0 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. Infant
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): Charleston, R#2 Mo 0

FATHER
13. NAME: James Dean, 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Eddyville, Kentucky 0

MOTHER
15. MAIDEN NAME: Daisy Bone,
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kennett, Mo

17. INFORMANT (ADDRESS): James Dean, Charleston, Mo R#2
18. BURIAL, CREMATION, OR REMOVAL: Charleston, Mo
PLACE: Oak Grove Cem DATE: 11/4/1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Lair-Nunnelee Charleston, Mo
20. FILED 11-8-1939 F D Vernon Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 11/4/39, 19

22. I HEREBY CERTIFY, That I attended deceased from on 11/3, 1939, to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 6am m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Premature
6 1/2 mo foetus

Other contributory causes of importance: 159

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) E. Chas Lalwing M. D.
745 (Address) Charleston Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2
District File Number 12 39-365
Date Filed 12-1

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.