

Registration District No. 89

Primary Registration District No. 3007

293

1. PLACE OF DEATH:  
(a) County Butler  
(b) City or town Poplar Bluff Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Brandon 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Willis Dell 460  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased October 14 1921  
(Month) (Day) (Year)

8. AGE: Years 18 Months 1 Days 20  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Pulaski County, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business 0

MOTHER FATHER  
12. Name S. E. Dell 0  
13. Birthplace Pulaski County, Mo. 0  
(City, town, or county) (State or foreign country)  
14. Maiden name Blanche Maze  
15. Birthplace Pulaski County, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature S. E. Dell

(b) Address Van Buren, Mo.

17. (a) Burial (b) Date thereof 12/6/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Van Buren, Mo.

18. (a) Signature of funeral director Croy-Leuckel Service

(b) Address Van Buren, Mo.

19. (a) 12/6/39 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Carter  
(c) City or town Rural  
(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 Dec. day 4  
year 1939 hour 7:15 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 1907  
24<sup>th</sup> 189 to Dec 4<sup>th</sup> 1939  
that I last saw him alive on Dec 4<sup>th</sup> 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Acute Cardiac Dilatation 12/4/39  
Due to Acute Nephritis 11/10/39  
Due to Acute Bronchitis 10/24/39  
Other conditions Pulmonary Edema 12/4/39  
(Include pregnancy within 3 months of death)

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 [Signature] (M. D. or other) [Signature]  
Address Poplar Bluff, Mo. Date signed 12/6/39

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 impor

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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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

42878  
Do not use this space.

1. PLACE OF DEATH  
(a) County Butler Registration District No. 89  
(b) Township Paplar Bluff Primary Registration District No. 3007 Registered No. 293  
(c) City Paplar Bluff (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 Willis Dell  
(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 8

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
18 1 20

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\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_, 19\_\_\_\_ Local Registrar \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 4, 19\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw him \_\_\_\_\_ 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:

acute cardiac dilatation  
acute nephritis  
following  
acute bronchitis  
Other contributory causes of importance:  
pulmonary edema  
Date of onset 10/6/18

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) C. L. Jaal, M. D.  
(Address) Paplar Bluff Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
REGISTRARS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

SUPPLEMENT

