

WHITE PLAINLY, WITH UNFADING INK---THIS IS 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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

43544
Do not use this space.

1. PLACE OF DEATH

(a) County Howell Registration District No. 384
(b) Township Horrell Primary Registration District No. 5535
(c) City West Plains 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 58 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>ma</u>	4. COLOR OR RACE <u>whit</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Alice Davis Hale</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 11 - 1869</u>		
7. AGE	YEARS <u>70</u>	MONTHS <u>5</u>
	DAYS <u>11</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>	
	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)	
FATHER	11. Total time (years) spent in this occupation <u>1</u>	
	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>	
MOTHER	13. NAME <u>Lezephiah Hale</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>	
MOTHER	15. MAIDEN NAME <u>Elizabeth Troutman</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>	
17. INFORMANT (ADDRESS) <u>Beth Hanna</u> <u>West Plains, Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Oak Lawn</u> DATE <u>11-25-1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Robertson</u> <u>West Plains, Mo</u>		
20. FILED <u>11-25</u> 19 <u>39</u> <u>Vida W SIMONS</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-23-1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 23, 1939, to Nov 23, 1939.

I last saw him alive on Nov 19, 1939. Death is said to have occurred on the date stated above, at 5:35 m.

The principal cause of death and related causes of importance were as follows:
Injury by fall
fracture of hip
11/15/39

Date of onset 11/15/39

Other contributory causes of importance:
chronic hypodermatitis
1935

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 11/15, 1939.
Where did injury occur? at home Horrell Co. Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury fall from
Nature of injury fracture of hip joint

24. Was disease or injury in any way related to occupation of deceased?
If so, specify:
(Signed) R. D. Gorman, M. D.
(Address) West Plains, Mo

DR Gorman

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.

RECEIVED

District Health Officer No. 5,

District File Number 14025

Date Filed 11040

Signed.....

[Handwritten Signature]

Licensed Embalmer No. 3482

P. O. Address West Plains 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.