

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. NO. 2
DOM-1-12-38
I X14023

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

44763
Do not use this space.

JAN 15 1940

1. PLACE OF DEATH *3*

(a) County *Lalaine* Registration District No. *796*

(b) Township *Marshall Mo* Primary Registration District No. *3938* Registered No. *200*

(c) City *Marshall Mo* (d) Street No. *Mo State School Marshall Mo* 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. *10* mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *635 Johnny Lee Dardens*

(a) Residence, No. *St Louis Mo* St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M*

4. COLOR OR RACE *Colored*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *6-10-37*

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

7	6	8	
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OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *minner*

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) *St Louis Mo*

FATHER

13. NAME *James Lee Dardens*

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

MOTHER

15. MAIDEN NAME *Loberta Rivale*

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

17. INFORMANT (ADDRESS) *St Louis Mo State School*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Mo State School* DATE *Dec 9 / 39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Fred Ferguson*
Ladonia Mo

20. FILED *12-9-39* 19. *39* *Mary Kent* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12-8/39*

22. I HEREBY CERTIFY, That I attended deceased from *2-6-*, 19*38*, to *12-8-*, 19*39*

I last saw him alive on *12-8-*, 19*39*. Death is said to have occurred on the date stated above, at *3:30* p.m.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage

Date of onset

Other contributory causes of importance: *g. 2. b*

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 *C. J. McConnell* M. D. (Signed) *7/2* (Address) *Marshall Mo*

RECEIVED
District Health Officer No. 8,
District File Number 114/40
Date Filed

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 F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address St. Albans

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.