

JAN 11 1940

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

44889
Do not use this space.

1. PLACE OF DEATH

(a) County Texas 2 Registration District No. 862
(b) Township Burdine 1 Primary Registration District No. 6135
(c) City _____ (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 un-named

(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 <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>11-28-39</u>				
7. AGE YEARS		MONTHS	DAYS	
<u>STILLBORN</u>			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.			
	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) <u>CABOOL, MO</u>				
FATHER	13. NAME <u>GENE DYKES</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>FORD CITY, MO</u>			
MOTHER	15. MAIDEN NAME <u>ELSIE HOYLE</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kansas</u>			
17. INFORMANT <u>Mrs JESS DYKES</u> (ADDRESS) <u>Cabool, Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Cabool, Mo</u> DATE _____ 19__				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>MORRIS 740</u>				
20. FILED <u>Dec 6, 1939</u> <u>Mrs. Christa Cunningham</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/28/1939

22. I HEREBY CERTIFY, That I attended deceased from 11/27/39 19__ to 11/28/39 19__
I last saw him/her 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:
Hydrannios
Open cephalic monster
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) Garyett Hogg Jr. M. D.
Cabool, Mo.

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.

WRITE CAREFULLY, WITH OMPASSING INSTRUMENTS IS A PERMANENT RECORD

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 14015

.....
11040

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.