

JAN 12 1940

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

6778  
Do not use this space.

1. PLACE OF DEATH

(a) County Kalt Registration District No. 375

(b) Township Rocky Primary Registration District No. 3322

(c) City 0 (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 Vera Fay Dennison

(a) Residence, No. Halt Co Rural St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Oliver Dennison

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 29, 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
39 2 12

OCCUPATION

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

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) Kalt County Mo

FATHER

13. NAME E. W. Smith

14. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Vernon Co Mo

MOTHER

15. MAIDEN NAME Fannie Braun

16. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Sam Smith, Mound City Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Cannon Cemetery DATE 2-14-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Crawford, Mound City Mo

20. FILED Feb. 12, 1940 Edith Dent Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 11, 1940

22. I HEREBY CERTIFY That I attended deceased from Feb. 11, 1940, to Feb. 11, 1940. I last saw her alive on Feb. 11, 1940. Death is said to have occurred on the date stated above, at 8:30 P. M.

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

Bronchopneumonia Date of onset Don't know

Other contributory causes of importance: Influenza

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? NO

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? NO If so, specify \_\_\_\_\_ (Signed) E. M. Furdley M. D. (Address) Mahau - Mo.

WRITE 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.

RECEIVED

District Health Officer No. 11,

District File Number 346-341

Date Filed 3-12-40

2021-21 1/11

---

---

**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 W. Crawford

Licensed Embalmer No. 1824

P. O. Address Manassas City, Md

**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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6778  
Registrar's No. 1

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 38

Primary Registration District No. 55-22

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Holt  
(b) City or town Hickory Grove  
(c) Name of hospital or institution:  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt  
(c) City or town Near Maitland, 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.

3. (a) PRINT FULL NAME

Vera Fay Desnison

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. SW

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
39 2 12 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Feb. 12, 1940 (Date received local registrar)  
Edith Dent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Feb day 11  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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 E. M. Findley (M. D. or other)  
Address Prabham Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-6778