

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 10580Registration District No. 246Primary Registration District No. 5209

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County Carter Pike, Mo.(b) City or town Butte, Mo.

(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 2

(Specify whether

In this community \_\_\_\_\_  
years, months or days 10-2 years3. (a) PRINT FULL NAME SARAH JANE NOR DYKE

3. (b) If veteran,

name war \_\_\_\_\_

3. (c) Social Security

No. \_\_\_\_\_

4. Sex F5. Color or race W6. (a) Single, widowed, married, divorced 6. (b) Name of husband or wife Mr. Nor Dyke

6. (c) Age of husband or wife if

alive 69 years7. Birth date of deceased 4

(Month)

6

(Day)

1896

(Year)

8. AGE:

Years

Months

Days

If less than one day

6397

hr.

min.

9. Birthplace Michigan

(City, town, or county)

(State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name H. C. Baker13. Birthplace Don't know

(City, town, or county)

(State or foreign country)

14. Maiden name Don't know

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature Clara Haalis(b) Address Fremont Mo.17. (a) Wichita Kans (b) Date thereof 3 17 40

(Burial, cremation, or removal)

(Month)

(Day)

(Year)

(c) Place: burial or cremation Wichita, Kansas18. (a) Signature of funeral director Phil A. Leuchter(b) Address Von Buren Mo.19. (a) March 14 (b) Jessie D. Schupp

(Date received local registrar)

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carter(c) City or town Butte

(If outside city or town limits, write "RURAL")

(d) Street No. 0

(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 13  
year 1940 hour 11 minute 30 P.M.21. I hereby certify that I attended the deceased from March 11  
1940, to March 13, 1940that I last saw her alive on March 13, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Broncho Pneumonia Duration 3 daysDiabetes MellitusSwing

Due to \_\_\_\_\_

Due to 54Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statistically.

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? 138While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_23. Signature J. M. Colton (M. D. or other) \_\_\_\_\_Address Von Buren Date signed 3-14-40

NOV 28

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 3-13-4

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

Signed \_\_\_\_\_

*Philip A. Leucke*

Licensed Embalmer No. 2936

No. Number 440 423

P. O. Address Von Bremen Mo

41150

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. 105-80

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 146

Primary Registration District No. 0209

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Carter  
(b) City or town Osola  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Sarah Jane Nordyke

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 5. (a) Single, widowed, married, divorced, married

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 63 Months 9 Days 7 If less than one day \_\_\_\_\_ 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)

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

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

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

(a) May 1948 (b) Jessie D. Schupp (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carter  
(c) City or town Fremont  
(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 3 day 13  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that last saw h. \_\_\_\_\_ 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 T. W. Cotton (M. D. or other)

Address Van Buren Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-10580 1940