

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

12181
Do not use this space.

1. PLACE OF DEATH *Jan 23 1940*
 (a) County Reynolds Registration District No. 747
 (b) Township Black River Primary Registration District No. 5080
 (c) City _____ or _____ (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 Rebecca Jane Dennison
 (a) Residence, No. Black 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 fem 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Benjamin Dennison
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 3, 1862
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 10 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. retired house wife
 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) Black Mo.

FATHER 13. NAME Re

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT Elmer Dennison
 (ADDRESS) Black Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Black Mo. DATE Dec. 6, 1939

19. FUNERAL DIRECTOR (NAME) Norman White & Sons
 (ADDRESS) Ironton Mo.

20. FILED March 30, 1940 mas 89 Perble
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1940, to Dec 4, 1939
 I last saw him alive on Dec 2, 1939 Death is said to have occurred on the date stated above, at 5:00 m.
 The principal cause of death and related causes of importance were as follows:

Chronic interstitial nephritis

Date of onset

Other contributory causes of importance:
Arterial Regurgitation

Name of operation _____
 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? _____ 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. W. Fickelbach M. D.
847 (Address) Westerfield, 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.

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.

District Health Officer No. 5,

Signed.....

District File Number 440 1119

Licensed Embalmer No.....

Date Filed 4/11/40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12181

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 747

Primary Registration District No. 3980

Registrar's No.

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Black River
(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 years, months or days

3. (a) PRINT FULL NAME Rebecca Jane Dennison

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

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

6. (b) Name of husband or wife Benjamin
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased Feb 3 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 1
If less than one day min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name unknown

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

14. Maiden name unknown

15. Birthplace unknown
(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 Norman White & Sons
Linton, Mo

19. (a) (b) (Date received local registrar) 6-1937

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (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

20. DATE OF DEATH Dec 4 1939
year month day hour minute M.

21. I hereby certify that I attended the deceased from Nov 2 1939
that I last saw her alive on Dec 2 1939
and that death occurred on the date and hour stated above. 5am
Immediate cause of death

Chronic Intestinal
Due to Nephritis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy no

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 C. M. Fitzpatrick
Address Leasdale

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

MOTHER-FATHER

TEMPORARILY

PHYSICIAN

Underline the cause to which death should be charged statistically.

1940
S-12181