

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

12740

Registration District No. 875 Primary Registration District No. 6162 State File No. ✓
 Registrar's No. 93

1. PLACE OF DEATH:
 (a) County Verde
 (b) City or town Rural Washington
 (c) Name of hospital or institution: State Hosp #3
 (d) Length of stay: 15 days
 In this community unknown

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Bates
 (c) City or town Amoret
 (d) Street No. Wm Knew
 (e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME O M Drysdale

3. (b) If veteran, name war unknown 8. (c) Social Security No. unknown

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

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 3 years

7. Birth date of deceased Oct 3 1861

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>5</u>	<u>17</u>	hr. min.

9. Birthplace unknown Indiana

10. Usual occupation Store Keeper

11. Industry or business Variety Store

12. Name Wm Drysdale

13. Birthplace unknown Kentucky

14. Maiden name Elizabeth Earnest

15. Birthplace unknown Tenn.

16. (a) Informant Hospital Records

(b) Address Nevada 770

17. (a) Private (b) Date thereof March 21 1940

(c) Place: burial or cremation Walc Hill Cemetery

18. (a) Signature of funeral director Butler

(b) Address Butler Mo 795

19. (a) 3/22/40 (b) Alban V. Davis

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Mar day 20 year 1940 hour 7 minute 25 A.M.

21. I hereby certify that I attended the deceased from Mar 5 1940 to Mar 20 1940
 that I last saw him alive on Mar 19 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to 107W

Other conditions Seizure

PHYSICIAN
 Major findings: Seizure
 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?
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature [Signature] (M. D. or other)
 Address State Hospital #3 Date signed 3/24/40

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

RECEIVED
District Health Officer No. 7
District Health 4-42-595
District File Number 4-8-40
State 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, _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed B. Stanton Lisle

Licensed Embalmer No. 4123

P. O. Address Buller, Mo

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. 12740

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 875-

Primary Registration District No. 6162

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Delmon
(b) City or town Washington Ins
(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)

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.

3. (a) PRINT FULL NAME

(b) If veteran, name war n.m.o

(c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
(b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE: Years 78 Months 5 Days 17 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Allen & Karp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 20
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 F.C. Long (M. D. or other) _____
Address State Hospital # 3 Date signed _____

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

SUPPLEMENTAL

S-12740-1940