

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr. Bronckers

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

14412
Do not use this space.

1. PLACE OF DEATH

(a) County Butler Registration District No. 89
 (b) Township 1 Primary Registration District No. 3007 Registered No. 114
 (c) City Poplar Bluff, Mo. (d) Street No. Brandon Hospital 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

200 Theodosia Dickey
 (a) Residence, No. Charleston, Missouri 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mr. O. F. Dickey

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
38 3 24

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) Centerville, Missouri (STATE OR COUNTRY)

FATHER 13. NAME John Williams

14. BIRTHPLACE (CITY OR TOWN) Centerville, Missouri (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Mrs. Elinor Williams

16. BIRTHPLACE (CITY OR TOWN) Chicago, Illinois (STATE OR COUNTRY)

17. INFORMANT Mr. O. F. Dickey (ADDRESS) Charleston, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Poplar Bluff, Mo. DATE 4/18/40

19. FUNERAL DIRECTOR (NAME) Frank Und. Company (ADDRESS) Poplar Bluff, Missouri

20. FILED 4/18 1940 Obitsinger Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 17, 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1940, to April 17, 1940
 I last saw her alive on April 17, 1940 Death is said to have occurred on the date stated above, at 7:30 A.M.
 The principal cause of death and related causes of importance were as follows:

Eclampsia Date of onset 3-28-40
146

Other contributory causes of importance:
Nephritis with Hypertension 3-4-40
 Name of operation Cesarean Date of 3-28-40
 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 Went to work! M. D.
 (Signed) Wm. J. ...
 (Address) Poplar Bluff, Mo.

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,

..... Scott A. Cotrell

....., or by B.J. Brentlinger

Registered Apprentice No. 208, working under my personal supervision.

Signed.....

Scott A. Cotrell

..... Licensed Embalmer No. 3567

..... P. O. Address Poplar Bluff, Missouri

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. 14412

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 89

Primary Registration District No. 3007

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Paplar Bluff
(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

Theodocia Dickray

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 m

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

7. Birth date of deceased Dec 23 1900
(Month) (Day) (Year)

8. AGE: Years 38 Months 3 Days 24 If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-6/40 (b) Obituary
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 17
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that I 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 M. L. Braydon _____ (or other) _____

Address Paplar Bluff _____ Date signed _____

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

SUPPLEMENTAL

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

S-14412