

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1937

State File No. _____

Registration District No. 757

Primary Registration District No. 3036

Registrar's No. 94

1. PLACE OF DEATH:
 (a) County St. Charles, Mo.
 (b) City or town "
 (c) Name of hospital or institution: St. Joseph's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 weeks
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Hubert Spencer Ciyon MD
 8. (b) If veteran, name war _____ 8. (c) Social Security No. 997-07-6350

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced wed
 6. (b) Name of husband or wife Margory Berniece (nee) Bryant 6. (c) Age of husband or wife if alive 21 years
 7. Birth date of deceased 27 Nov. 29-1915
 (Month) (Day) (Year)

8. AGE: Years 24 Months 6 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation farming

11. Industry or business _____
 12. Name Morgan Spencer Ciyon
 13. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Janice Pawlson
 15. Birthplace Moscow Mills Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Hubert Ciyon
 (b) Address Winfield, Mo.

17. (a) Winfield (b) Date thereof 6/1/40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Burial in Winfield

18. (a) Signature of funeral director Charles Reaks
 (b) Address Winfield, Mo.

19. (a) 5/31/40 (b) Clarence H. Heester
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Lincoln
 (c) City or town Winfield - Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3 miles East of Winfield
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30
 year 1940 hour 12 minute 50 p.M.
 21. I hereby certify that I attended the deceased from 5/16, 1940, to 5/30, 1940
 that I last saw him alive on 5/30, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus Empyema
 Due to Perinephritic abscess
 Due to Peritonal appendicitis
 Other conditions _____
 (Include pregnancy within 3 months of death)

Duration 2 wks.
6 wks.
6 wks.
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

Major findings: Proptosed, offensive perinephritic abscess, empyema
 Of autopsy not made

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? 679
 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature B. L. Newbiser (M. D. or other) MD
 Address St. Charles Mo. Date signed _____

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.

Signed.....

Garlan Ricks

Licensed Embalmer No.....

4012

P. O. Address.....

Winfield, 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.