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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31950**

FILED OCT 18 1940

Registration District No. **294** Primary Registration District No. **4178**

Registrar's No.

1. PLACE OF DEATH:

(a) County **FRANKLIN**
(b) City or town **ST. CLAIR**
(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 **3**
(Specify whether

In this community **5 days**
years, months or days) (Specify whether

8. (a) PRINT FULL NAME **DOLLIE MAE KEMP**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **FEB 24 1890**
(Month) (Day) (Year)

8. AGE: Years **50** Months **7** Days **4** If less than one day hr. min.

9. Birthplace **NEW HAVEN MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business

MOTHER FATHER { 12. Name **GEORGE DYSON**

13. Birthplace **NEW HAVEN MO**
(City, town, or county) (State or foreign country)

14. Maiden name **MELVINA MORRIS**

15. Birthplace **Don't know**
(City, town, or county) (State or foreign country)

16. (a) Informant **Opal Aitch.**

(b) Address **Washington mo.**

17. (a) **BURIAL** (b) Date thereof **Oct 1, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BALTIMORE P. M.**

18. (a) Signature of funeral director **L. C. FERTIG & SON**

(b) Address **NEW HAVEN MO.**

19. (a) **OCT 9, 1940** (b) **W. H. ...**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Franklin**

(c) City or town **New Haven**
(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 **SEP** day **28**
year **1940** hour **6** minute **11** M.

21. I hereby certify that I attended the deceased from **SEP 20**
1940 to **SEP 28**, 19**40**
that I last saw her alive on **SEP 28**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death

Acute Endocarditis

Due to

Due to **121**

Other conditions: (include pregnancy within 3 months of death)
Chronic Hypertension

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?

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

23. Signature **W. H. ...** (M. D. or other)

Address **Dr. ...** Date signed **9/28/40**

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

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 me

Registered Apprentice No. 3385

working under my personal supervision.

Signed

Carl Fertig

Licensed Embalmer No. 3385

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.