

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

34926
Do not use this space.

NOV 15 10 11 AM

1. PLACE OF DEATH

(a) County Butler Registration District No. 89

(b) Township Pepper Buff Primary Registration District No. 5131

(c) City near Fisk (d) Street No. _____ (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 Dennis Lee Gregory

(a) Residence, No. Fisk 9th RR. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 27 - 1937

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

2 11 20

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. Baby.

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) mo.

13. NAME U.S. Gregory

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

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ada Pyle mo.

17. INFORMANT (ADDRESS) Mother Mrs. Ada Gregory Fisk

18. BURIAL, CREMATION, OR REMOVAL PLACE Bernie DATE Oct. - 17 - 40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Landers Service Campbell mo.

20. FILED 10-19-40 Belstamans Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Oct. 16 - 6 P.M., 1940, to Oct. 17, 1940.

I last saw him alive on Oct. 16, 1940. Death is said to have occurred on the date stated above, at 1:30 p.m.

The principal cause of death and related causes of importance were as follows:

Diphtheria

Date of onset Oct 15

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) T. H. Parsley M. D.

(Address) Fisk

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.....

Licensed Embalmer No.....

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.