

DEC 12 1940

Registration District No. 342

Primary Registration District No. 342 5484

State File No. _____

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Harrison
 (b) City or town Hatfield
 (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 10 years
 years, months or days

3. (a) PRINT FULL NAME EUGENE DEMPSEY

2. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Mary E. Dempsey 6. (c) Age of husband or wife if alive 80 years
 7. Birth date of deceased 7 16 1957
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>3</u>	<u>16</u>	hr. _____ min. _____

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER
 { 12. Name Perry Dempsey
 { 13. Birthplace Unknown
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Unknown
 { 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant Mary E. Dempsey
 (b) Address Hatfield, Mo.

17. (a) Burial (b) Date thereof 11 3 40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Center

18. (a) Signature of funeral director Arch C. Dangle

(b) Address Small City, Mo.

19. (a) Nov 9 (b) W. C. Adams
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Harrison
 (c) City or town Hatfield
 (If outside city or town limit, 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 Nov. day 25
 year 1940 hour 7 minute 30 AM

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on 2 years ago, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death
No doctor in attendance for the last two years
 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 G. W. Reynolds (M. D. or other)
 Address Hatfield Mo. R. 5 Date signed Nov 6

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Arch C Dunfee

Licensed Embalmer No. *3250*

P. O. Address. *Leant City, N*

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. 38791

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 346

Primary Registration District No. 2484

Registrar's No. _____

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

MOORE

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town Lincoln T. P.
(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 _____
In this community _____ (Specify whether 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 Eugene Dempsey
(b) If veteran, name war _____
3. (c) Social Security No. _____

20. DATE OF DEATH: Month Nov day 2 year _____ 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.

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

Immediate cause of death No Dr in attendance Duration _____

7. Birth date of deceased _____ (Month) (Day) (Year)
8. AGE: Years 83 Months 3 Days 16 If less than one day _____ hr _____ min.

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

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

Major findings: Of operations _____

10. Usual occupation _____

Of autopsy _____

11. Industry or business _____

22. If death was due to external causes, fill in the following:

12. Name _____

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

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

(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? _____

14. Maiden name _____

(Specify type of place) _____ (e) Means of injury _____

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

While at work? _____

16. (a) Informant _____
(b) Address _____

23. Signature A. W. Reynolds (M. D. or other) _____
Address Mount Airy Iowa Date signed _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) Chas. Adair (Registrar's signature)
(Date received local registrar)

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

SUPPLEMENTARY

