

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39654

State File No. _____

Registration District No. 273

Primary Registration District No. 6018A

Registrar's No. 196

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Near Farmington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 7 mo. 21 d.
(Specify whether
In this community _____
years, months or days) 3

3. (a) PRINT FULL NAME James F. Hale

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Arrie Wyle 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 4th 1853
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 9 10 hr. _____ min.

9. Birthplace Mine LaMotte Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Unknown

13. Birthplace New Madrid Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace New Madrid Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records of State Hospital No. 4
(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 11-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cem. of State Hosp #1

18. (a) Signature of funeral director Richardson Funeral Home
(b) Address Farmington, Mo.

19. (a) Nov 23 1940 (b) T. J. Robinson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
(c) City or town Commerce
(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 11 day 16
year 1940 hour 12 minute 20 A. M.

21. I hereby certify that I attended the deceased from 3-25, 1940, to 11-16, 1940
that I last saw him alive on 11-15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Peritonitis
Duration five days

Due to Bilateral Pyelonephrosis and Persistent Cystitis and Prostatitis, organism not determined.

Other conditions Arteriosclerosis, generalized, bilateral
Arterio-sclerosis, generalized, bilateral
Arterio-sclerosis, generalized, bilateral
(Include pregnancy within 3 months of death) One year +

Major findings: Of operations 127

Of autopsy Generalized peritonitis, bilateral pyelonephrosis, cystitis + prostatitis, arteriosclerosis.

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 C. C. Auto

23. Signature C. C. Auto (M. D. or other) M. D.
Address Farmington, Mo. Date signed 11/20/40

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.....

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

working under my personal supervision.

Signed Paul K. Dwyer

Licensed Embalmer No. 4120

P. O. Address Farmington,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.