

FILED JAN 13 1941

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

41978

Do not use this space.

## 1. PLACE OF DEATH

(a) County Butler 2 Registration District No. 89  
 (b) Township Neely 0 Primary Registration District No. 513D  
 (c) City..... (d) Street No..... St.  
 (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 1 yrs. 5 mos. 22 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 3832. PRINT FULL NAME BOBBY DONALD DELL

(a) Residence, No. BUTLER COUNTY St.   
 (Usual place of abode, if no street address, write county or city) (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*) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 6, 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
1 5 22

OCCUPATION

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.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Butler County 0  
 (STATE OR COUNTRY) Missouri

13. NAME Ed Dell 1

14. BIRTHPLACE (CITY OR TOWN) Clay County  
 (STATE OR COUNTRY) Arkansas 0

15. MAIDEN NAME Ruthy Verdier 0

16. BIRTHPLACE (CITY OR TOWN) Osberry, Missouri  
 (STATE OR COUNTRY)

17. INFORMANT Charlie Dell  
 (ADDRESS) Neelyville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Williams cemetery DATE Dec. 29, 1940

19. FUNERAL DIRECTOR (NAME) Grady Service  
 (ADDRESS) Carmine Ark

20. FILED 12/30, 1940 Kate Lutz  
 Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 28, 1940

22. I HEREBY CERTIFY, That I attended deceased from 12/24, 1940 to 12/28, 1940

I last saw him alive on 12/26, 1940. Death is said to have occurred on the date stated above, at 8:15 A.M.

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

Pneumonia ✓

Date of onset

Other contributory causes of importance:

Name of operation none Date of

What test confirmed diagnosis? ✓ Was there an autopsy? no

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 no

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) John W. Rine M. D.

(Address) Carmine Ark

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**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 41978

Registration District No. 89

Primary Registration District No. 5130

Registrar's No. 383

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Neely T.P.  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Bobby Donald Dell

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced X

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 5 22 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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.

DEATH CERTIFICATION

20. DATE OF DEATH: Month Dec day 28 year 1940 hour \_\_\_\_\_ minute A M.

21. I hereby certify that I attended the deceased from 12/25 1940 to 12/27 1940 that I last saw him alive on 12/27 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 3 days  
Tuber Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 John W. Bruce M.D. (M. D. or other) \_\_\_\_\_

Address 16 Arming Ave Date signed 2/4/41

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

SUPPLEMENTARY

