

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

**43559**  
Do not use this space.

**REC** JAN 25 1941

**1. PLACE OF DEATH**

(a) County Boek Registration District No. 703  
 (b) Township Johnson Primary Registration District No. 4424  
 (c) City Humansville (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Vyle ss Oval Deputy

(a) Residence, No. Humansville, Mo (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) Widowed

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

**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)** Aug 25, 1856

**7. AGE** YEARS 84 MONTHS 3 DAYS 15 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**OCCUPATION**

**8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.** Retired

**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) (STATE OR COUNTRY)** Missouri

**FATHER**

**13. NAME** William B. Deputy  
**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Ind.

**MOTHER**

**15. MAIDEN NAME** Elmira Barber  
**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Ind.

**17. INFORMANT (ADDRESS)** H. C. Deputy Humansville, Mo

**18. BURIAL, CREMATION, OR REMOVAL**  
 PLACE Memphis TN DATE Dec 12, 1940

**19. FUNERAL DIRECTOR (NAME) (ADDRESS)** Joseph F. Finston Humansville, Mo

**20. FILED** Dec. 11, 1940 Geo. M. Reel  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** Dec 10, 1940

**22. I HEREBY CERTIFY, That I attended deceased from** Dec 2, 1940 to Dec 10, 1940  
 I last saw him alive on Dec 10, 1940. Death is said to have occurred on the date stated above, at 9:30 pm.  
 The principal cause of death and related causes of importance were as follows:  
Tumor of esophagus  
Probable carcinoma Date of onset 8 mos

Other contributory causes of importance: 46

Name of operation none 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) Roscoe C. Newins, M. D.  
 (Address) Humansville, Mo.

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.

RECEIVED

District Health Officer No. 7,

District File Number 1-41-57

Date Filed 1-9-41

**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 R. A. Joseph

Licensed Embalmer No. 3149

P. O. Address Humansville

**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.**

Registration District No. 703

Primary Registration District No. 4424

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Polk  
(b) City or town Humansville  
(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) WYLESS ORVAL

3. (a) PRINT FULL NAME Wyless Orval DEPUTY  
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 wid  
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 84 Months 3 Days 15 If less than one day \_\_\_\_\_ 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) Dec. 11-40 (b) Orval M. Rich  
(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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month Dec day 10  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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 Roscoe C. Reyna (M. D. or other) \_\_\_\_\_  
Address Humansville Date signed Dec 11 1940

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

SUPPLEMENTARY

YU930  
-AV50 22311V

S-43559

1950-1951