

No. 2  
12-403  
17-39  
X23159

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1720

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Ellis Tracheal State Cancer Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs DELLA MAE DALE

3. (b) If veteran, name war -

3. (c) Social Security No. -

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mr. W. H. Dale 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased May 11 1893  
(Month) (Day) (Year)

8. AGE: Years 47 Months 7 Days 20 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business "

12. Name Daniel Harrison

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

14. Maiden name Elizabeth Allen

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

16. (a) Informant Local Burial Record

(b) Address Boone Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3 - 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Elmer, Mo.

18. (a) Signature of funeral director Clyde McCallum

(b) Address Elmer, Mo.

19. (a) 1/2/41 (Date received local registrar) (b) Allie Selby (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Elmer (If outside city or town limits, write "RURAL")

(d) Street No. none (If rural, give location)

(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1st year 1941 hour 4 minute 30 AM.

21. I hereby certify that I attended the deceased from 12-24 1940 to Jan 1 1941 that I last saw her alive on 12-31 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary and skeletal metastasis

Due to from base of breast

Due to 50

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?

74 While at work? (Specify type of place) (e) Means of injury -

23. Signature Engene M. Bricker (M. D. or other) h

Address Ellis Tracheal State Cancer Hosp. Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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, fact should be so stated above.**