

FEB 25 1941

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

3840  
Do not use this space.

1. PLACE OF DEATH

(a) County Phelps Registration District No. 677  
(b) Township Miller Primary Registration District No. 5903  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
(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.

Registered No. 24  
011 St.

2. PRINT FULL NAME

(a) Residence, No. William L. Dyke  
Rolla, Mo. 1 Rural  
(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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 4, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
83 10 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
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) Marion Co Missouri

13. NAME Leftridge Dykes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Jane Joyce

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Mrs C F Castleman  
Grant City Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Macedonia Cem DATE 1/17 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs Harry M. Cant  
Rolla, Mo.

20. FILED Jan 17 1941 J. F. Myers  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/15 1941

22. I HEREBY CERTIFY, That I attended deceased from 1-1- 1941 to 1-15 1941  
I last saw him alive on 1-15 1941 Death is said to have occurred on the date stated above, at 5:00 P.M.  
The principal cause of death and related causes of importance were as follows:

pneumonia Date of onset 1-1-41

Other contributory causes of importance:

Smoking

Name of operation \_\_\_\_\_ 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) E. E. Friend M. D.  
Rolla Mo  
(Address) Rolla 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.

104

RECEIVED

District Health Officer No 5,

District File Number 241203

Date Filed \_\_\_\_\_

STATE HEALTH DEPARTMENT

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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed \_\_\_\_\_

*R. J. McCaw*

Licensed Embalmer No. \_\_\_\_\_

3953

P. O. Address \_\_\_\_\_

*Ralla*

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

Registration District No. 677

Primary Registration District No. 5903

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

1. PLACE OF DEATH

- (a) County Phelps
- (b) City or town Rolla  
(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 \_\_\_\_\_  
years, months or days

- 3. (a) PRINT FULL NAME Wm L. Dykes
- 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 \_\_\_\_\_ years
- 7. Birth date of deceased (Month) (Day) (Year) \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>10</u>	<u>12</u>	hr. min.

- 9. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_
- 10. Usual occupation \_\_\_\_\_
- 11. Industry or business \_\_\_\_\_
- MOTHER FATHER { 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 \_\_\_\_\_  
(Burial, cremation, or removal) (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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 1 day 15 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death Pneumonia (bronchial) Duration 2 weeks

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

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

Other conditions Senility  
(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 E. E. Friend (M. D. or other) \_\_\_\_\_  
Address Rolla Date signed 7-27

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

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3840

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 677

Primary Registration District No. 5903

Registrar's No.

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

1. PLACE OF DEATH

(a) County Phelps  
(b) City or town Miller, 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 (Specify whether)  
In this community years, months or days

3. (a) PRINT FULL NAME

Wm L. Dykes

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 W

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 83 Months 10 Days 12

If less than one day hr. min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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) (Burial, cremation, or removal)

(b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar)

(b) (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 1 day 15 -  
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.

Immediate cause of death pneumonia (broncho) Duration 2 wks

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) sensibly 197

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?

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

23. Signature E. E. Ferid M.D. Rolla Mo. Date signed

SUPPLEMENTARY