

S. No. 2
-11-10-39
v. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8447**
Registrar's No. **54**

FILED **MAR 17 1941**
Registration District No. **875**

Primary Registration District No. **3039**

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1
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Nevada
(c) Name of hospital or institution:
Public Highway #71454 on E. Washburn St.
(d) Length of stay: In hospital or institution _____
In this community Transient
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Bourbon
City or town Ft. Scott
(d) Street No. 211 N. Crawford
(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME Marrin Paul Dumolt
3. (b) If veteran, name war no
3. (c) Social Security No. 509-16-1572

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 9, A. M. hour 2:15 minute 1
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Elaine Dumolt 6. (c) Age of husband or wife if alive 18 years
7. Birth date of deceased: Dec 22, 1922
(Month) (Day) (Year)

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

8. AGE: Years 18 Months 1 Days 17 If less than one day hr. _____ min. _____

Immediate cause of death:
Skull fracture
Fracture of radius
+ ulna
Fracture of femur
multiple abrasions
and lacerations
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace Billingville, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Mechanic

11. Industry or business Garage

12. Name William H. Dumolt

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

14. Maiden name Estelne T. Brammiller

15. Birthplace Arrow Rock, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Michelle J. Dumolt
(b) Address 211 N. Crawford St. Scott, Kan.

17. (a) Removal (b) Date thereof 2/11/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ft. Scott, Kansas

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) accident
(b) Date of occurrence 2-9-41
(c) Where did injury occur? Nevada, Vernon, Mo.
(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) (e) Means of injury Collision

23. Signature C. Bryan Davis (M. D. or other) _____
Address Rogers Bldg., Nevada Date signed 2-10-41

17026
98

RECEIVED

District Health Officer No. 7,

District File Number 3-41-454

Date Filed 3-7-41

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

Lloyd R. Wainwright

Licensed Embalmer No.

2857

P. O. Address

Neuada, Mo

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.

No. 2
1-4-41
5-17-39
X263

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

WENA MOORE

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8447

Registration District No. 875

Primary Registration District No. 3039

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Neada

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

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 _____

3. (a) PRINT FULL NAME Marvin Paul Dumas

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 m

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>18</u>	<u>1</u>	<u>17</u>	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 _____
(City, town, or county) (State or foreign country)

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9
year 1941 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: Fracture of skull fracture Duration _____
Fracture of radius/ulna
Fracture of femur
Multiple abrasions and lacerations

Due to [Was on motorcycle and hit by a car]

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations 170 lb

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) acc

(b) Date of occurrence 2-9-1941

(c) Where did injury occur? Neada (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Underpass (54271) Nevada (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Abraham Davis (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENT

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.