DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH 14956

STANDARD CERTIFICATE OF DEATH

FILED MAY 10 1941

State File No. 14956

Registration District No. 449 Primary Registration District No. 4267 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pulaski
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Near Dixon (If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Dale Joseph Aaron
3. (b) If veteran, name war
3. (c) Social Security No. none

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased June 3, 1923 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	17	10	8	hr. min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name John W. Aaron
13. Birthplace Missouri (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Dora Craine
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant John W. Aaron
(b) Address Dixon, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/1941 (Month) (Day) (Year)
(c) Place: burial or cremation Pisgah Cemetery
18. (a) Signature of funeral director Fred H. Gilbert
(b) Address Dixon, Mo.
19. (a) 4-15-41 (Date received local registrar) (b) J. A. McComb (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 11 year 1941 hour 1:30 minute P. M.
21. I hereby certify that I attended the deceased from 4/10/ 1941, to 4/11/ 1941; that I last saw h_m alive on 4/11/ 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fractured Skull	24 hrs
Due to Auto-accident	
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) Accident car
(b) Date of occurrence 4/10/41
(c) Where did injury occur? Dixon Pulaski Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Road (Specify type of place)
While at work? No (e) Means of injury

23. Signature Wm. J. Lesarlige (M. D.)
Address Lebanon Date signed 4/12/41

(Licensed Embalmer's Statement on Reverse Side)

1786
98

RECEIVED
District Health Officer No. 7,
District File Number 5-41-829
Date Filed 5-9-41

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.....
Dorsey M Howe, Registered Apprentice No. 256
working under my personal supervision.

Signed W. E. Holman

Licensed Embalmer No. 4107

P. O. Address Lebanon, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
4-25-41
I X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14957

Registration District No. 449 Primary Registration District No. 4267 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon (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)

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 Dale Joseph Aaron
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 S
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 17 Months 10 Days 8 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 11 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.

	Duration
Immediate cause of death Fractured skull	12 hr
Due to auto accident (another auto - collision)	12 hr
Due to Head on collision c another auto.	

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) accident auto collision
(b) Date of occurrence 4-10-1941
(c) Where did injury occur? Dixon public Rd (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Road (Specify type of place)
While at work? (e) Means of injury
23. Signature W. J. Wallace (M. D. or other) M.D.
Address Lebanon Date signed 6/21/41

SUPPLEMENTARY COPY