

3-40  
7-39  
(231)59

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 15 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

25116

State File No. \_\_\_\_\_  
Registrar's No. 581

Registration District No. 318

Primary Registration District No. 2001

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

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: Burge Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days  
(Specify whether years, months or days)

In this community 0 years, months or days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Dykes Barbara Sue

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced Inf

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased May 20 1941  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>1</u>	<u>25</u>	hr. _____ min. _____

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

10. Usual occupation Inf

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name Dykes, Frank

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

14. Maiden name Patterson, Marie

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

16. (a) Informant Dykes, Mrs. Frank

(b) Address Stratford, Mo

17. (a) Removal (b) Date thereof July 15 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Danforth

18. (a) Signature of funeral director J. W. Klingner

(b) Address Springfield, Mo

19. (a) 7-14-41 (b) W. E. Handley MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Unknown <sup>039</sup>

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

(d) Street No. Route 1  
(If rural, give location)

(e) If foreign born, how long in U. S. A. 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 15  
year 1941 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from 7-1-41, 19\_\_\_\_, to 7-15-41, 19\_\_\_\_;  
that I last saw he alive on 7-14-41, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital malformation of heart

Due to 1572

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

Duration life

Due to life

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

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

Signature Urban B. ... (R. D. or \_\_\_\_\_)

Address Springfield, Mo Date signed 7-15-41

**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.....

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.**