

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 17 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29250

Registration District No. 775

Primary Registration District No. 622 a

Registrar's No. 55

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Boone Terre
(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 _____)

3. (a) PRINT FULL NAME MINNIE BELL DICKENS
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White
6. (a) Single, widow/d, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 13 1895
(Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____
MOTHER FATHER { 12. Name Benjamin Suddath
13. Birthplace Unknown?
(City, town, or county) (State or foreign country)
14. Maiden name Martha Holland
15. Birthplace Unknown?
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Robert Murphy
(b) Address Boone Terre Mo

17. (a) Burial (b) Date thereof Aug 2 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francois Cemetery

18. (a) Signature of funeral director Benjamin Co
(b) Address Boone Terre Mo

19. (a) 8-20-41 (b) N W Hawbin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Boone Terre
(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.? 0 years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 31
year 1941 hour 7 minute 4 M.
21. I hereby certify that I attended the deceased from April 13
1939 to July 31, 1941;
that I last saw her alive on July 31, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 3 yrs.

Due to _____
Due to _____
Other conditions Coronary disease 1 yr.
(Include pregnancy within 3 months of death)

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) _____
(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 Marvin L. Haw (M. D.) CMD.
Address Boone Terre, Mo Date signed 8-20-41

FEB 23 1943

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 C. J. Claywell
Licensed Embalmer No. 3706
P. O. Address Bound Brook, N.J.

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.