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FILED OCT 18 1941

 MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No.

29730

Registration District No.

791

Primary Registration District No.

1003

Registrar's No.

7068

1. PLACE OF DEATH:

- (a) County _____
- (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:
22224 DELMAR 1
(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 MISSOURI (b) County 31 000
- (c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
- (d) Street No. 22224 DELMAR 9
(If rural, give location)
- (e) Citizen of foreign country? _____ (Yes or No)
- Attending Physician

3. (a) PRINT FULL NAME JIM DYSON

3. (b) If veteran,

name war _____

3. (c) Social Security

No. None

4. Sex MALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)
7. Birth date of deceased 7 4 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

45 1 27 _____ hr. _____ min.

9. Birthplace 1 TENNESSEE
(City, town, or county) (State or foreign country)10. Usual occupation L.H.B.O.R.

11. Industry or business _____

12. Name JOHN GLENN Dyson13. Birthplace COVINGTON TENN
(City, town, or county) (State or foreign country)14. Maiden name MARTHA FLOWERS15. Birthplace COVINGTON TENNESSEE
(City, town, or county) (State or foreign country)16. (a) Informant Barey Flowers(b) Address Evergreen Hts, Kenlock MO17. (a) SKIPPED (b) Date thereof 9-1-1941
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation COVINGTON TENN18. (a) Signature of funeral director Boyd Bro F.N. HOME(b) Address 3704 Finney19. (a) SEP 2 1941 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30
year 1941 hour 6 minute _____ P. M.21. I hereby certify that I attended the deceased from _____
_____ 19____, to _____ 19____;

that I last saw him _____ alive on _____ 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic MyocarditisChronic NephritisDue to PneumoniaDue to 13/6

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) _____

(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) (b) Means of injury (Seal)23. Signature Thomas Halleran (M. D. or other) _____Address Deputy Coroner Date signed 9/2/41

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.

Myself

Signed *Glenn E. Anderson*

Licensed Embalmer No. *4141*

P. O. Address *St. Louis Mo*

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29730

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St Louis
 (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 Jim Dyson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race n 6. (a) Single, widowed, married, divorced si

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 7-4-1895
 (Month) (Day) (Year)

8. AGE: Years 45 Months 1 Days 10 (If less than one day, in min.)

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

10. Usual occupation _____

11. Industry of business _____

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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. NOV 21 1941 (Date received by Registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 1941 year, hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

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) _____

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

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



