

Registration District No. **508**

Primary Registration District No. **5807**

1. PLACE OF DEATH:  
(a) County Newton  
(b) City or town Franklin  
(c) Name of hospital or institution:  
Stella, no R41  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution in own home  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME ROBERT IRL DYER  
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 Married  
6. (b) Name of husband or wife Ruth Dyer 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 26 1899  
(Month) (Day) (Year)

8. AGE: Years 42 Months 6 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace McDonald Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

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

MOTHER FATHER  
12. Name A. M. Dyer  
13. Birthplace Ill. (City, town, or county) (State or foreign country)  
14. Maiden name Ann Scott  
15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature R. Dyer  
(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof Oct 6 41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Macedonia Cem

18. (a) Signature of funeral director Wm. Morris Tome  
(b) Address Wheeler, Mo

19. (a) 11-1-1941 (b) Ada Collins  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Newton  
(c) City or town Rural (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Oct day 4 year 1941 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from Sept. 19 1941 to Oct. 4 1941; that I last saw him alive on Oct. 4 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid fever

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 8 months of death) \_\_\_\_\_

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 \_\_\_\_\_

23. Signature J. B. Edmondson (M. D. or other) \_\_\_\_\_  
Address Stella, Mo Date signed 8/24

Duration 1 1/2 days  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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.

RECEIVED

District Health Officer No. 6,

District File Number 1141-1692

Date Filed NOV 8 1941

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**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 Wm Morris Pogue

Licensed Embalmer No. 3442

P. O. Address Wheaton 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.**