

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 27

FILED APR 7 1943

141

3025

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County... Howell
(b) City or town... West Plains, Mo.
(c) Name of hospital or institution:
West Plains Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... 12 Hours
(Specify whether
in this community... 15 Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... Missouri (b) County... Howell
(c) City or town... Mountain View, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No... Rural
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Shirley Ann Dynes

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced... Child
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive... years
7. Birth date of deceased... May 22 1936
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 7 11 hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name Frank M Dynes
13. Birthplace Calif.
(City, town, or county) (State or foreign country)
14. Maiden name Loretta Grose
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Glen Crouch
(b) Address Mtn View, Mo
17. (a) Removal (b) Date thereof Jan 4th 43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Joseph, Mo

18. (a) Signature of funeral director John F Duncan
(b) Address Mountain View, Mo

19. (a) 3-25-43 (b) Shirley Ann Dynes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2nd
year 1943 hour 9 minute 30 a.m.

21. I hereby certify that I attended the deceased from 1/1 1943 to 1/2 1943
that I last saw him alive on 1/2 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis
Due to Rupt of appendix & obstructed ileum
Due to 12/11
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Rupt appendix, Peritonitis, obstructed ileum
Of autopsy _____

Duration
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 Maurice Thompson (M. D. or other) MD
Address West Plains Date signed 1/4/43

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

RECEIVED

District Health Officer No. 5,

District File Number 442195-

Date Filed 4-5-73

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

John J. Arman

Licensed Embalmer No. 2516

P. O. Address

1111 1/2 W. 9th St.

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.