

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25579
Registrar's No. 30

LED JUL 30 1943
Registration District No. 37

Primary Registration District No. 5830

V. S. No. 2-A
50M-3-42
Revised 1-23-1937

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

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.

1. PLACE OF DEATH:
 (a) County NEW MADRID COUNTY
 (b) City or town Gideon Mo. R.F.D. No 1
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Anderson Farm
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 in this community all of life
 years, months or days

2. (a) PRINT FULL NAME Yvonne Entrikin
 (b) If veteran, name war _____ (c) Social Security No. _____

3. (a) Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, single
 (b) Name of husband or wife husband Clyde W. Entrikin 6. (c) Age of husband or wife if alive 39 years
 Birth date of deceased Aug 20 1941
 (Month) (Day) (Year)

AGE:	Years	Months	Days	If less than one day
	1	10	3	hr. min.

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

8. Usual occupation _____
 9. Industry or business _____

12. Name Clyde Entrikin.
 13. Birthplace New Madrid Missouri. (City, town, or county) (State or foreign country)
 14. Maiden name Silva Thornbrough.
 15. Birthplace East Prairie, Missouri. (City, town, or county) (State or foreign country)

(a) Informant _____
 (b) Address Gideon, Missouri.
Stanfield Cem. (c) Date thereof June 24th. 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)
Stanfield Cem.
 (c) Place: burial or cremation.

(a) Signature of funeral director R.B. Meentemeyer.
 (b) Address Gideon, Missouri.
 (c) June 25/43 (d) Sandra Macon
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County New Madrid
 (c) City or town Gideon Mo. R.F.D. No 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 23rd
 year 1943 hour 3 PM minute _____ M.
 21. I hereby certify that I attended the deceased from June 16, 1943
 _____, 19____, to June 23, 1943.
 that I last saw her alive on June 23rd, 1943.
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Discolitis
 Due to dehydration
 Duration 11 days
7 days

Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: 119a
 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?
 _____ (Specify type of place) (e) Means of injury _____
 23. Signature John Van Cleve (M. D. or other)
 Address Gideon Mo Date signed 6/25/43

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LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MARGIN RESERVED FOR BINDING

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. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

(b) City or town.....
(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)

3. (a) PRINT FULL NAME.....

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

4. Sex.....	5. Color or race.....	6. (a) Single, widowed, married, divorced.....	
6. (b) Name of husband or wife.....		6. (c) Age of husband or wife if alive..... years	

7. Birth date of deceased.....
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER: FATHER: { 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.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
 (b) Address.....

19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

(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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
 year..... hour..... minute.....

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.....

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 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.....
(Specify type of place)
 While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

Duration

PHYSICIAN

Under the cause which death should be charged historically