

FILED FEB 7 1945

Registration District No. 248

Primary Registration District No. 5843

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Newton County Missouri

(b) City or town "Rural" Five Mile Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Galena, Kans. R.R. #2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 18 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton **73**

(c) City or town "Rural" **0**  
(If outside city or town limits, write "RURAL")

(d) Street No. Five Mile township **0**  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) **(1)**  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Andrew C. Dinnsen

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 5  
year 1945 hour 11 minute 30 A.M.

4. Sex Male **0** 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Dortha A. Dinnsen 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased May 20 1865  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 10, 1944, to Jan 5, 1945  
that I last saw him alive on Jan 1, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years 79 Months 7 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Chronic Myo-Carditis

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation Farmer

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

12. Name Broder Dinnsen

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

14. Maiden name Anna C. Autzen

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

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? \_\_\_\_\_

16. (a) Informant Freida Borum

(b) Address Adena, Colorado

17. (a) Burial (b) Date thereof 1 7 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hurnet, Missouri

18. (a) Signature of funeral director B. B. Buzzard

(b) Address Seneca, Missouri

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

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature T. B. Dinnsen (M. D. or other) **0**  
Address Seneca, Mo Date signed 1-7-45

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

3000

1362

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED FEB 5 1945

District Health Officer No. \_\_\_\_\_  
District File Number 145-9  
Date Filed FEB 5 1945

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 B. W. Buzzard  
Licensed Embalmer No. 2334  
P. O. Address Seneca, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb  
Registrar's No. \_\_\_\_\_

Registration District No. 248 Primary Registration District No. 5843

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

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Rural 5 mi. N. Hwy  
(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 Andrew C. Demise

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 m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 22  
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Jan. 29 '45 (b) Nettie Morris  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day \_\_\_\_\_  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 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)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

2966