. S. No. 2
0M—5-43
v. 5-17-39
1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23355

FILED JUL 16 1945

Registration District No. ____ Primary Registration District No. 3002 Registrar's No. 87

1. PLACE OF DEATH:

(a) County Audrain

(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 906 N. Mo. Ave. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community 75 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Audrain 4

(c) City or town Mexico 1
(If outside city or town limits, write "RURAL")

(d) Street No. 906 N. Missouri Ave. 21
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country ____

3. (a) PRINT FULL NAME Emma Jane Dinwiddie

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife ____

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

7. Birth date of deceased July 17, 1875 (Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 12 If less than one day ____ hr. ____ min.

9. Birthplace Indiana (City, town, or county) 1 (State or foreign country)

10. Usual occupation Widow

11. Industry or business ____

FATHER
12. Name Joe Morris
13. Birthplace Ind. (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name DK
15. Birthplace DK 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jimpie Robert
(b) Address Mexico, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-1-45 (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Victor Arnold
(b) Address Mexico, Mo.

19. (a) 6-30-45 (Date received local registrar) (b) Margaret H Mackey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29 year 1945 hour 9 minute 35 A. M.

21. I hereby certify that I attended the deceased from June 29, 1945, to 6-29-45, 19__; that I last saw her alive on 6-29-45, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Liver & Stomach

Due to Primary Seat in Ascending Colon.

Due to ____

Other conditions (Include pregnancy within 3 months of death) ____

Major findings:
Of operations H&P

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature W. Van Tyngerdam M.D. (or other) ____
Address Mexico Mo. Date signed 6-30-45

1074

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 7-45-1136
Date Filed JUL 13 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 .....

Licensed Embalmer No. 3569

P. O. Address .....

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.