No. 2
—8-43
5-17-39
I X37823

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

FILED AUG 9 1945

State File No. 25240

Registration District No. 348 Primary Registration District No. 4512 Registrar's No. 72

**1. PLACE OF DEATH:**

(a) County Sullivan

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

(c) Name of hospital or institution: Dale Hospital 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether In this community 15 days. years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Ray 89

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

(d) Street No. ..... 1 (If rural, give location)

(e) Citizen of foreign country? yes (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME WALTER R. Berry Dale

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

4. Sex M. O 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Kate Dale 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased April (Month) 8 (Day) 1864 (Year)

8. AGE: Years 81 Months 3 Days If less than one day ..... hr. ..... min.

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

10. Usual occupation Farmer

11. Industry or business .....

FATHER
12. Name Joashush Dale
13. Birthplace ..... (City, town, or county) Kentucky (State or foreign country)

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

16. (a) Informant Dr. G. A. Dale

(b) Address Newtown Mo.

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

(c) Place: burial or cremation Dale Cemetery Ray Co Mo.

18. (a) Signature of funeral director Judd & Payne

(b) Address Newtown Mo.

19. (a) Aug. 2-45 (Date received local registrar) (b) Greta Caldwell (Registrar's signature)

1380

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 22 year 1945 hour 10 minute P.M.

21. I hereby certify that I attended the deceased from July 15, 1945, to July 22, 1945 that I last saw him alive on July 22, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Coronary occlusion | 5 minutes |
| Due to arteriosclerosis + hypertension | |
| Due to Chronic glomerulo nephritis | |
| Other conditions (Include pregnancy within 3 months of death) possible carcinoma of liver | |
| Major findings: Of operations ..... Of autopsy ..... 46 | |

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 Elias L. Judd (M.D. or other) D.O.

Address Unionville Mo. Date signed 7-25-45

(Licensed Embalmer's Statement on Reverse Side)

## 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 T. Howard Judd

Licensed Embalmer No. 3240

P. O. Address Houlton Me

**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.**

S. No. 2B
M—3-45
I X43880

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. Aug

Registration District No. 348 Primary Registration District No. 4512 Registrar's No. 72

**1. PLACE OF DEATH:**
(a) County Sullivan
(b) City or town Newtown
(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 years, months or days)
In this community

**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

3. (a) PRINT FULL NAME Walter B. Dale
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 Apr 8 (Month) (Day) (Year)
8. AGE: Years 81 Months 3 Days 4 If less than one day hr. min.
9. Birthplace (City, town, or county) Missouri (State or foreign country)
10. Usual occupation
11. Industry or business
12. FATHER Name
13. FATHER Birthplace (City, town, or county) (State or foreign country)
14. MOTHER Maiden name
15. MOTHER Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Dr. G. G. Dale
(b) Address Newtown Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Aug. 18-45 (Date received local registrar) Greta Caldwell (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug Day 2 year 1945 hour minute M.
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 — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

1945
S-25240