. S. No. 2
M—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED OCT 4 1945

State File No. 30129

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 953

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 87 days (Specify whether years, months or days)

In this community 25 years at Summer Mo

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Chariton

(c) City or town: Summer
(If outside city or town limits, write "RURAL")

(d) Street No.: Rural RFD #1
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: HUGH C. DYER

3. (b) If veteran, name war: X

3. (c) Social Security No.: X

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: Deceased

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

7. Birth date of deceased: July (Month) 29 (Day) 1881 (Year)

8. AGE: Years 64 Months 1 Days 4 If less than one day hr. min.

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

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: James Drew
13. Birthplace: Sullivan (City, town, or county) Ill (State or foreign country)

MOTHER
14. Maiden name: Susan Davis
15. Birthplace: Sullivan (City, town, or county) Ill (State or foreign country)

16. (a) Informant: Record Hospital
(b) Address: St Joseph Mo

17. (a) Burial (Burial, cremation or removal) (b) Date thereof: 9-5-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Slater City Cemetery

18. (a) Signature of funeral director: Jones & Salzer
(b) Address: Slater Mo

19. (a) 9-12-45 (Date received by local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 3 year 1945 hour 9 minute 9 A.M.

21. I hereby certify that I attended the deceased from 8-6, 1945, to 9-2, 1945, that I last saw him alive on 9-2, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage

Due to: arteriosclerosis

Due to:

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

Major findings:
Of operations:

Of autopsy: [signature]

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: [signature] (M. D. or other)

Address: St Joseph Mo Date signed: 9-2-45

1428

(Licensed Embalmer's Statement on Reverse Side)

OCT 27 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 Jas E Jones

Licensed Embalmer No. 3143

P. O. Address Slater 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.