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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8651  
Registrar's No. 121

**FILED** APR 10 1946

Registration District No. 3007

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

1. PLACE OF DEATH:  
Butler  
(a) County  
(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Poplar Bluff Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Months years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Stoddard  
(c) City or town Bell City, Rural  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME ALVIN DALE DEJOURNETT  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Infant  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 4, 1945  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	--	4	28	hr. _____ min.

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

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

12. Name Alvin DeJournett  
13. Birthplace Stoddard co. Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Gladys Warren  
15. Birthplace Stoddard Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Alvin DeJournett  
(b) Address Bell City, Mo. Route # 1.

17. (a) Burial (b) Date thereof Apr. 2-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Gravel Hill cemetery

18. (a) Signature of funeral director Chiles Und. Co.  
(b) Address Bloomfield, Mo.

19. (a) 4-6-46 (b) Ch. Mustice  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31st  
year 1946 hour 5 P. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 3-31 1946 to 3-31 1946

that I last saw him alive on 3-31 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition Duration \_\_\_\_\_

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

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

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

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

Of autopsy 158

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? \_\_\_\_\_

Signature H. Henrickson B.S., M.D.  
Address Poplar Bluff, Mo. Date signed Apr 46

RECEIVED

District Health Office No.

District File Number 446-50

Date Filed 4-9-46

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**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 *No Embalming*.....

Licensed Embalmer No.....

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.**