

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Barnes Hospital, 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **25 days**
In this community **25 Days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Madison 999**
(c) City or town **Roxana**
(If outside city or town limits, write "RURAL") **NR!**
(d) Street No. **Walnut St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JAMES EIMER DYER**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Ruth Dyer** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **October 22 1884**
(Month) (Day) (Year)

8. AGE: Years **62** Months **2** Days **6** If less than one day hr. min.

9. Birthplace **Athensville Illinois 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer, Retired**

11. Industry or business **Own Farm**

12. Name **Samuel Morgan Dyer**

13. Birthplace **Unknown Tennessee 1**
(City, town, or county) (State or foreign country)

14. Maiden name **Virginia Whiteside**

15. Birthplace **Unknown Unknown 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ruth Dyer**

(b) Address **Walnut St. Roxana, Illinois.**

17. (a) **Barnes Hospital** (b) Date thereof **Dec. 31, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Alton, Illinois**

18. (a) Signature of funeral director **Robert D. Stregger**

(b) Address **2521 Edwards St. Alton, Ill.**

19. (a) **DEC 30 1946** (b) **J. Z. Brunck**
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **28**
year **1946** hour **9** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **Dec. 3 1946** to **Dec. 28 1946**
that I last saw him alive on **December 28 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized peritonitis** Duration _____

Due to **Perforation of large bowel**

Due to **Carcinoma of the colon**

Other conditions (Include pregnancy within 3 months of death) **Ho**

Major findings: Of operations _____

Of autopsy **none performed**

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? **0**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **F. R. Bradley** (M. D. or other)
Address **Barnes Hospital,** Date signed **12-28-46**

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.....

Robert H. Streepes

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Robert H. Streepes*

Licensed Embalmer No. *2474*

P. O. Address..... *Alton, Ill.*

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.