

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43334

State File No. _____

Registration District No. 373

Primary Registration District No. 6270

Registrar's No. 68

1. PLACE OF DEATH:

(a) County Webster

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

(c) Name of hospital or institution: X

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X (Specify whether)

In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster 112

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. E. Union township 0
(If rural, give location)

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

If yes, name country X

3. (a) PRINT FULL NAME Dale Edwin Cain

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife X

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

7. Birth date of deceased August - 20 - 1946
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>no</u>	<u>no</u>	<u>7</u>	<u>X</u> hr. <u>X</u> min.

9. Birthplace Niangua, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business X

MOTHER FATHER {

12. Name George William Cain 0

13. Birthplace Webster County, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Geneva Pauline Reece

15. Birthplace Oklahoma 1
(City, town, or county) (State or foreign country)

16. (a) Informant Geo. Wm. Cain

(b) Address Niangua, Missouri

17. (a) Burial (b) Date thereof 8-28-46
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Good Spring

18. (a) Signature of funeral director Tex J. Jolley

(b) Address Marshfield, Missouri

19. (a) 12/17/46 (b) J. J. McPherson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27
year 1946 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from Aug 21, 1946, to 2, 1946
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death night fever
Pneumonia fever

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 108

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? !!

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

23. Signature W. F. Schlicht (M. D. or other) 12/17/46

Address Niangua Date signed 146

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

112
0
0

RECEIVED

District Health Officer No. 6,
District File Number 1246-1254
Date Filed DEC 26 1948

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. _____

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.