

FILED AUG 4 1947

State File No.

Registration District No. 77

Primary Registration District No. 5297

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Clinton
(b) City or town Holt Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

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

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

In this community _____
years, months or days

3. (a) PRINT FULL NAME BARBARA JEAN DYKES

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced U

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 28 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 20 hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Clarence M. Dykes
13. Birthplace Lansure Idaho
(City, town, or county) (State or foreign country)
14. Maiden name Essie Smithers
15. Birthplace Bruno Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Harce Smithers
(b) Address Holt Mo

17. (a) Burial (b) Date thereof Sept 29-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakland Cern

18. (c) Signature of funeral director Leonard Fry

(b) Address Kearney Mo

19. (a) _____ (b) Harce Smithers (Registrar's signature) 10/10
(Date received local registrar) (Date)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clinton 25
(c) City or town Holt Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29th
year 1946 hour 1 minute a.m.

21. I hereby certify that I attended the deceased from Sept 28 1946 to Sept 29 1946
that I last saw her alive on Sept 29 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Intracranial hemorrhage of atheros.
Rachitic pelvis of mother with terupt. expulsive force on head of infant.

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

Major findings: _____

Of operations _____
Of autopsy _____

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 Peter E. Buchner (M. D. or other) 0
Lansure Mo Date signed Sept 30

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

Not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Leonard Fry*.....

Licensed Embalmer No. *1677*.....

P. O. Address *Kearney 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.