

**FILED FEB 10 1947**

Registration District No. \_\_\_\_\_

Primary Registration District No. 3002

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Adair County  
(b) City or town Kirksville, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Laughlin Hospital  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution Four days  
In this community Entire life  
years, months or days (Specify whether)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Shelby 102  
(c) City or town Shelbina, Missouri 2  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location) 1  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Cecil William Dale

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 Married

6. (b) Name of husband or wife Mildred Dale 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased March 30th 1910  
(Month) (Day) (Year)

8. AGE: Years 36 Months 9 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Drug Store Clerk

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Issac Thomas Dale

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

14. Maiden name Ethel Heathman

15. Birthplace Shelby County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mildred Dale

(b) Address Shelbina, Missouri

17. (a) Burial (b) Date thereof 1-19-1947  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbyville, Mo.

18. (a) Signature of funeral director Million & Barkelew  
Shelbina, Mo.

(b) Address \_\_\_\_\_

19. (a) 21347 (b) Kate Lambert  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month January day 17th  
year 1947 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from January 14th 1947 to January 17 1947  
that I last saw him alive on January 17 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death: Congestive Heart failure Duration 4 days  
Rheumatic Heart Disease Due to 15 years

Other conditions: 93E  
(Include pregnancy within 3 months of death)

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

Of autopsy: No Autopsy  
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 2

23. Signature A. T. Rhoads (M.D. or other)  
Kirksville, Mo. Date signed 1-19-47

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

RECEIVED  
District of Columbia  
District File No. 2-47-277  
Data File FEB - 5 1947

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.....

*W. Hawkins*

Licensed Embalmer No. *3498*

P. O. Address *Shelton Md*

**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.**

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirksville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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 Cecil W. Dale

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased mar 30 (Month) (Day) (Year)

8. AGE: Years 36 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 2-13-47 (b) Kate Lambert (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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

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

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

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

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER, FATHER

