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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27218**
Registrar's No. **81**

Registration District No. **99** Primary Registration District No. **5374**

1. PLACE OF DEATH:
(a) County **DeKalb**
(b) City or town **Rural - Colfax Twp.**
(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 **2 yrs.**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **DeKalb** **32**
(c) City or town **Maysville - Rural** **3**
(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 _____

3. (a) PRINT FULL NAME **William Dyas**
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **3**
year **1947** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from **Jan 1947**
_____ 19 _____ to **July 28 1947**
that I last saw him alive on **28 June 1947**
and that death occurred on the date and hour stated above.

4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Single**
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **July 27, 1868**
(Month) (Day) (Year)

Immediate cause of death _____ **Chronic Valvular heart Disease** **932**
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
78 **11** **16** hr. min.

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

9. Birthplace **Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Labor**

11. Industry or business _____

12. Name **John Dyas**

13. Birthplace **Pennsylvania**
(City, town, or county) (State or foreign country)

14. Maiden name **Louisa Dice**

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

16. (a) Informant **Donald Dyas**

(b) Address **Maysville, Missouri**

17. (a) _____ (b) Date thereof **7/6/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Grove Cemetery**

18. (a) Signature of funeral director **F. G. Dyas**

(b) Address **St. Louis, Missouri**

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 **Frank Jones** (M. D. or other) _____

Address **Camden, Mo** **Date signed** **8-6-47**

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

MOTHER FATHER

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *F. G. Lyon*

Licensed Embalmer No. *952*

P. O. Address *Stewartville 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.

Registration District No. 99 Primary Registration District No. 5374

1. PLACE OF DEATH:
(a) County DeKalb
(b) City or town Rural
(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

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 _____

3. (a) PRINT FULL NAME William Dyer
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 S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased July 27 (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July 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 _____

8. AGE: Years 78 Months _____ Day _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
MOTHER } 12. Name _____
FATHER } 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)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) Rose Davidson (Date received local registrar) (Registrar's signature)

Duration _____
Due to _____
Due to _____
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 _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

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

5-272A