S. No. 2
—12-45
5-17-39
P I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33707

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 1263

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: State Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 yrs 3 mos 4 days (Specify whether

In this community 20 yrs. 3 mos. 4 days. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay

(c) City or town Excelsor Springs (If outside city or town limits, write "RURAL")

(d) Street No. — (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Marie A. Dale

3. (b) If veteran, name war No

3. (c) Social Security No. Nil

4. Sex Female

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 — (Month) — (Day) 1909 (Year)

8. AGE: Years 38 | Months — | Days — | If less than one day hr. min.

9. Birthplace Excelsor Springs Mo (City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name Lee Dale
13. Birthplace Excelsor Springs Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Bertha Francis
15. Birthplace Not given (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Bertha Dale

(b) Address Excelsor Springs

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/47 (Month) (Day) (Year)

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

18. (a) Signature of funeral director Heaton-Bowman

(b) Address St. Joseph, Mo.

19. (a) 10-24-47 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 21 year 1947 hour 4 minute 40 P M.

21. I hereby certify that I attended the deceased from Jan 1st, 1947 to 10-21, 1947; that I last saw her alive on 10-21, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis epilepsy — Duration 1 wk

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. Lossing M.D. (M. D. or other)

Address State Hospital #2 St. Joseph, Mo. Date signed 10/21/1947

(Licensed Embalmer's Statement on Reverse Side)

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 Francis J. Wyland Jr., Registered Apprentice No. 444, working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 3195 10th St. St. Joseph, 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.