

FILED MAR 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4523**

Registrar's No. **214-13**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY Greene b. CITY (If outside corporate limits, write RURAL and give town) Springfield c. LENGTH OF STAY (In this place) 2 weeks		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dallas c. CITY (If outside corporate limits, write RURAL and give township) Buffalo d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) Bent b. (Middle) Dalton c. (Last) Dalton		4. DATE OF DEATH (Month) (Day) (Year) March 4, 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 1, 1878
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. BIRTHPLACE (State or foreign country) Indiana
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	12. CITIZEN OF WHAT COUNTRY? U. S.
13a. FATHER'S NAME Nicholas Dalton		13b. MOTHER'S MAIDEN NAME Margaret Wilkes	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Ben Harrison		ADDRESS Buffalo, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma stomach. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) none. DUE TO (c) none. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uremia terminally	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION none.	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-20-1949 , to 3-4-1949 , that I last saw the deceased alive on 3-3-1949 , and that death occurred at 6:29 a. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edw. C. Schenkler, M.D.		23b. ADDRESS 805 Woodruff Bldg., Spfld. Mo.	
23c. DATE SIGNED 3-7-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-6-49	
24c. NAME OF CEMETERY OR CREMATORY Macedonia Cemetery		24d. LOCATION (City, town, or county) (State) Dallas County Missouri	
DATE REC'D BY LOCAL REG. 3/11/49		REGISTRAR'S SIGNATURE W.E. Handley	
25. FUNERAL DIRECTOR'S SIGNATURE L. B. Jones		ADDRESS Buffalo, Missouri	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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.