

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20554**

0.300  
0.48

DECEASED MAY 26 1953

BIRTH NO. _____		REG. DIST. NO. <b>374</b>		PRIMARY REG. DIST. NO. <b>4557</b>		Registrar's No. <b>15</b>			
1. PLACE OF DEATH a. COUNTY <b>Worth</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Worth</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sheridan</b>		c. LENGTH OF STAY (In this place) <b>7 yrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sheridan</b>		<b>1130</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) <b>0</b>					
3. NAME OF DECEASED (Type or Print) <b>James W</b>			a. (First) <b>W.</b>		b. (Middle) <b>Dyer</b>		c. (Last) <b>Dyer</b>		
4. DATE OF DEATH <b>May 16, 1953</b>		4. DATE (Month) <b>May</b>		4. DATE (Day) <b>16,</b>		4. DATE (Year) <b>1953</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>May 3, 1878</b>			
9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 HR. Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer and blacksmith</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>Mt. Ayr, Iowa</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>									
13a. FATHER'S NAME <b>Annias Dyer</b>			13b. MOTHER'S MAIDEN NAME <b>Margret Norris</b>			14. NAME OF HUSBAND OR WIFE <b>Never married</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Beryl Haley</b>					
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) <b>Cerebral Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis Generalized</b>				DUE TO (c) <b>Pernicious Anemia</b>				3 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								10 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>331X</b>						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) (m.)		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 <b>1947</b> to <b>May 16, 1953</b> , that I last saw the deceased alive on <b>May 16, 1953</b> , and that death occurred at <b>2 P.</b> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Frank B. Matzson M.D.</b>				23b. ADDRESS <b>Grant City, Mo.</b>		23c. DATE SIGNED <b>5-19-53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5-19-1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Watterson Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Ringgold County, Iowa</b>			
DATE REC'D BY LOCAL REG. <b>May 22-1953</b>		REGISTRAR'S SIGNATURE <b>Letta C. Dawson</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Billy A. Dunfee</b>		ADDRESS <b>Grant City, Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

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**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 Billy A Duffee

Licensed Embalmer No. 4908

P. O. Address Grant City, 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.