

FILED APR 8 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

## 1. PLACE OF DEATH

County Henry Registration District No. 347  
 Township Clinton Primary Registration District No. 5478  
 City Clinton - mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 11096

Registered No. \_\_\_\_\_

2. FULL NAME Raymond Kent Dall(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-30-19407. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
5

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Clinton mo (STATE OR COUNTRY) 013. NAME Ralph Dall 014. BIRTHPLACE (CITY OR TOWN) Union mo (STATE OR COUNTRY) 015. MAIDEN NAME Nina Grossheart16. BIRTHPLACE (CITY OR TOWN) Bates Co (STATE OR COUNTRY)17. INFORMANT Ralph Dall (ADDRESS)18. BURIAL, CREMATION, OR REMOVAL PLACE Mullin DATE April 3 194019. UNDERTAKER W. D. Brown (ADDRESS)20. FILED April 8 1940 J. R. Hampton Registrar.W. D. Brown

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-3 194022. I HEREBY CERTIFY, That I attended deceased from 3-30- 1940, to 4-3 1940I last saw him alive on 4-3 1940 Death is saidto have occurred on the date stated above, at 6:00 a.m.

The principal cause of death and related causes of importance were as follows:

Hemorrhagic Purpura Date of onset 4-2-40  
2 diaphoreticOther contributory causes of importance: 70W

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Ernest S. Neville M. D.(Address) Clinton, Mo.

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CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No.....  
 City..... (No....., ..... St. .... Ward)

**2. FULL NAME**.....

(a) Residence, No..... St., ..... Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX		4. COLOR OR RACE		5. SINGLE, MARRIED, WIDOWED, OR DIVORCED ( <i>write the word</i> )	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)					
7. AGE		YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....				
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....				
	10. Date deceased last worked at this occupation (month and year).....		11. Total time (years) spent in this occupation.....		
12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)					
FATHER	13. NAME				
	14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)				
MOTHER	15. MAIDEN NAME				
	16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)				
17. INFORMANT (ADDRESS)					
18. BURIAL, CREMATION, OR REMOVAL					
PLACE..... DATE.....19.....					
19. UNDERTAKER (ADDRESS)					
20. FILED..... 19.....					

*Registrar.*

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR)....., 19.....

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset
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Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify.....  
 (Signed)....., M. D.  
 (Address).....

\*N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.