

REC'D AUG 22 1939

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

Do not use this space.

1. PLACE OF DEATH

County Texas
Township Piney
City Houston

Registration District No. 863
Primary Registration District No. 6137

File No. 27071
Registered No. 22
St. _____ Ward _____

2. FULL NAME

VAN NOTE

(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 M 4. COLOR OR RACE W 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) July 23 / 1939

7. AGE YEARS MONTHS DAYS if LESS than 1 day, _____ hrs. or _____ min.

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) Houston Mo

13. NAME Lyle Van Note

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mason City Ia

15. MAIDEN NAME Delma Stryak

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Willow Springs

17. INFORMANT Lyle Van Note
(ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Willow Springs DATE July 25 1939

19. UNDERTAKER S. V. Elliott
(ADDRESS) _____

20. FILED July 26 1939 Mabel Shacklett
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 25 1939

22. I HEREBY CERTIFY, That I attended deceased from July 25 1939, to July 25 1939
I last saw him alive on July 25 1939. Death is said to have occurred on the date stated above, at 12:30 AM.
The principal cause of death and related causes of importance were as follows:

Atelectasis of lungs of newborn.

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) R. M. Deffen M. D.

(Address) Houston Mo

161a

RECEIVED

District Health Officer No. 5,

District File Number 839 98

Date Filed 8/10/39

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

27071 Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. (b) Township Jiney Primary Registration District No. (c) City (d) Street No. (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Infant Saw Gate (a) Residence, No. (Usual place of abode, if no street address, write county or city) St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 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) 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or 30 min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as 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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local 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 him 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

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) L. M. Dyllman, M. D. (Address) Houston Tex

SUPPLEMENTARY

1612

1939

S-27071