

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.

DEC 12 1939
Registration District No. **460**

Primary Registration District No. **4272**

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Ladue, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME ALBERT R. DEW
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex ma. 5. Color or race white 6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife FLORENCE DEW 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 3 1891
(Month) (Day) (Year)

8. AGE: Years 48 Months 3 Days 22 If less than one day hr. _____ min. _____

9. Birthplace Maynardville Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____
MOTHER FATHER { 12. Name Not Known
13. Birthplace Not Known
(City, town, or county) (State or foreign country)
14. Maiden name Not Known
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Glorance Parker
(b) Address St. Louis, Mo

17. (a) Burial (b) Date thereof 12-1-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Licking, Mo

18. (a) Signature of funeral director Winstler
(b) Address Lexington, Mo

19. (a) DEC. 4-39 (b) Tiffany Webb
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 25 year 1939 hour 7 minute 5 A. M.
21. I hereby certify that I attended the deceased from 25 Nov. 39 to Nov. 25, 1939.
that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Skull fracture Duration _____

Due to Falling from freight train
Due to _____

Other conditions (Include pregnancy within 3 months of death) no

Major findings: Of operations _____
Of autopsy no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Nov. 25, 1939
(c) Where did injury occur? 1 mi. E. Columbia
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Rail Road rightway
(Specify type of place) (e) Means of injury Train
While at work? no
23. Signature T. B. Nisbet, M.D. (M. D. or other) _____
Address Odessa, Mo Date signed 11/30/39

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO LISTENER
DATE 12/1/74

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Garrest J. Tempel

Licensed Embalmer No. 3275

P. O. Address Lexington, Va.

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, above space should be left blank.