

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

40275

Do not use this space.

1. PLACE OF DEATH

(a) County Mississippi Registration District No. 566

(b) Township Tywapity Primary Registration District No. 3030

(c) City Charleston (d) Street No. _____ Registered No. 127 St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(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 Will DeKine

(a) Residence, No. Charleston, Mo St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Color

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 25th, 1885

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

74 7 20

OCCUPATION

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. Retired Farmer

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) Ripley Tennessee

FATHER

13. NAME Robert DeKine

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

MOTHER

15. MAIDEN NAME Dont Know

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

17. INFORMANT (ADDRESS) Susie DeKine Charleston, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove Cem DATE 11/16/1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lair-Nunnelee Charleston, Mo

20. FILED 11-18-39 F. Overm Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/15/39

22. I HEREBY CERTIFY, That I attended deceased from about May 31 to 11/15 1939

Last saw h. alive on 11/14 1939 Death is said to have occurred on the date stated above, at 12:10pm

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

Chronic Fibrosis D.K.

Arteriosclerosis D.K.

Other contributory causes of importance: Edema

Name of operation none Date of _____

What test confirmed diagnosis? Cl. lymph Was there an autopsy? no

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? no

If so, specify E. Chas. Fleming M. D.

(Signed) Chas Fleming

(Address) Charleston Mo

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.

RECEIVED

District Health Officer No. 2
District File Number 1239-377
Date Filed 12-1

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.....

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, above space should be left blank.