

Registration District No. 448 Primary Registration District No. 5608

1. PLACE OF DEATH: 2
(a) County Laclede Mo.
(b) City or town Conway-Rural-R.F.D. 1
(c) Name of hospital or institution: X
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X
In this community 4 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Perry Commodore Dakan
3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Iva Dakan 6. (c) Age of husband or wife if alive years
7. Birth date of deceased November 21, 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 7 If less than one day hr. min.

9. Birthplace Andrew Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Iva Dakan
(b) Address Conway, Missouri-R.F.D. 1.

17. (a) Burial (b) Date thereof Feb 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wood house

18. (a) Signature of funeral director Cec. J. J. J. J.
(b) Address Marshfield, Missouri

19. (a) 2-9-40 (b) A. R. A. Martiney
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Conway-rural-R.F.D. 1
(If outside city or town limits, write "RURAL")
(d) Street No. X (If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 28
year 1940 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from Jan 27-30
Jan 25, 1940, to Jan 28, 1940,
that I last saw him alive on Jan 25, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage,
apoplexy.

Due to 1
Due to 1

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature W. F. Schlicht (M.D. or other)
Address St. Louis, Mo. Date signed Jan 31

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.

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.