

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FILE MAR 2 - 1940

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

7171
Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 469

(b) Township Lincoln Primary Registration District No. 5630

(c) City 0 (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Jessie C. Dinderguss

(a) Residence, No. 536 Miller Mo. St. (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) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-11-1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 82 1 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at Home

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

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) Indiana

FATHER 13. NAME UNKNOWN

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

MOTHER 15. MAIDEN NAME UNKNOWN

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

17. INFORMANT (ADDRESS) Mrs. Virgil Cottrell Miller Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Ray Springs DATE 2-18-1940

19. FUNERAL DIRECTOR (ADDRESS) Mohr & Deimon Miller Mo.

20. FILED 3-1-1940 E. D. Bunnery Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-17-1940

22. I HEREBY CERTIFY, That I attended deceased from 2-1-1940, to 2-17-1940. I last saw him alive on 2-14-1940. Death is said to have occurred on the date stated above, at 12 A. M.

The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia Date of onset _____

Other contributory causes of importance: _____

Name of operation none Date of _____

What test confirmed diagnosis? _____ 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? _____

If so, specify _____

(Signed) E. D. Bunnery M. D.

(Address) Miller Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 3210-6017

Date Filed MAR 5 1940

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

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.)