WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11093

Registration District No. 347 Primary Registration District No. 5488 Registrar's No.

1. PLACE OF DEATH: Henry
(a) County Henry
(b) City or town Near Clinton Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.R. #5
(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)

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.

3. (a) PRINT FULL NAME George H Dehn
3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife Marretta 6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 21 (Day) 1869 (Year)

8. AGE: Years 70 Months 10 Days 21 If less than one day hr. min.

9. Birthplace (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Farming
11. Industry or business
FATHER 12. Name Peter Dehn
13. Birthplace (City, town, or county) Germany (State or foreign country)
MOTHER 14. Maiden name Susannah Meise
15. Birthplace (City, town, or county) Germany (State or foreign country)
16. (a) Informant's own signature Mrs Will Hoppe
(b) Address Clinton Mo RR
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-40 (Month) (Day) (Year)
(c) Place: burial or cremation Englewood
18. (a) Signature of funeral director Consalus & Peck
(b) Address Clinton Mo
19. (a) 3-16-40 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3-11 day [illegible] year 1940 hour 7 minute 30 A.M.
21. I hereby certify that I attended the deceased from July, 1939, to Feb 11, 1940; that I last saw h[illegible] alive on Feb 11, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pernicious anemia [illegible] Hemorrhage from Kidney	2 yr
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN — Underline the cause to which death should be charged statistically.
Of autopsy	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature G. L. Walker (M. D. or other) M.D.
Address Clinton Mo Date signed 3-12

(Licensed Embalmer's Statement on Reverse Side)

1 X19311

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 J. E. Consolino

Licensed Embalmer No. 1891

P. O. Address Clinton

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.

No. 2B
-2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11093

Registration District No. 347 Primary Registration District No. 3488 Registrar's No.

1. PLACE OF DEATH:
(a) County Henry (b) City or town Clinton Iowa
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Henry
(c) City or town Clinton Mo RR 5
(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.

3. (a) PRINT FULL NAME Geo H. Dehn
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 70 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 3—16-40 (Date received local registrar) (b) W J R Hamilton (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 11
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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

23. Signature G. E. Walker (M. D. or other)
Address Clinton Date signed

No. 2B
2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11093

Registration District No. 347

Primary Registration District No. 3488

Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Henry
(b) ~~City or town~~ Clinton Ins
(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
In this community (Specify whether years, months or days)

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(c) City or town (If outside city or town limits write "RURAL")
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3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married divorced Wd

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 11 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Pernicious anemia Hemorrhage from Kidney | Duration
Due to I dont know cause of Hemorrhage, may have been
Due to malig. inf.

Other conditions (Include pregnancy within 3 months of death) 133 P

Major findings:
Of operations
Of autopsy

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

23. Signature G. S. Walker (M. D. or other)
Address Clinton Mo. Date signed