

1. PLACE OF DEATH:  
 (a) County Buchanan  
 (b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution Missouri Methodist Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 days  
(Specify whether)  
 In this community life  
years, months or days

3. (a) PRINT FULL NAME EARL L. DYKES 220

3. (b) If veteran, name war none 3. (c) Social Security No. 401-10-5364

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Addie 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased May 21 1908  
(Month) (Day) (Year)

8. AGE: Years 32 Months 2 Days 23 If less than one day  
hr. min.

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

10. Usual occupation W P A

11. Industry or business \_\_\_\_\_

12. Name Gillispie Dykes

13. Birthplace St. Joseph, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Laura Cremen

15. Birthplace Clarinda Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Addie Dykes

(b) Address 1511 North 13th Street

17. (a) burial (b) Date thereof 8-17-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St. Joseph Missouri

19. (a) Aug 17 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) 0 Missouri (b) County Buchanan  
 (c) City or town Saint Joseph  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1511 North 13th Street  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14  
 year 1940 hour 8 minute 05 P.M.

21. I hereby certify that I attended the deceased from Aug. 11  
 \_\_\_\_\_, 1940, to Aug. 14, 1940

that I last saw him alive on August 14, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Perforated Gastric Ulcer

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations Perforated Gastric Ulcer  
 Of autopsy same, Inverted Ulcer and Gastro-enterostomy woundstperforated

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? \_\_\_\_\_

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address St. Joseph Mo Date signed 8/17/40

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

1  
5  
7

802

**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 Me

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Geo E Daniel

Licensed Embalmer No. 3300

P. O. Address St Joseph Mo

**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, fact should be so stated above.**