

1941 OCT 12 (961)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31848**

Registration District No. **238** Primary Registration District No. **0326** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Dade**
(b) City or town **Rockwood Rural**
(c) Name of hospital or institution: **Dade Co. Central San Ship**
(d) Length of stay: In hospital or institution _____
In this community **all life** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **DADE**
(c) City or town **Rural**
(d) Street No. **near Arcola**
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **JOHN FYFE**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **JAN** day **15th** year **1940** hour **8:30** minute **8** M.

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife **OLLIE** 6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **SEPT. 3 - 1868**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death **D**

8. AGE: Years **71** Months **4** Days **12** If less than one day _____ hr. _____ min.

Due to **Died without a registered Dr. in attendance.**
Due to **Pneumonia**

9. Birthplace **DADE CO MO**
10. Usual occupation **Farming**
11. Industry or business **owner**
12. Name **J M Fife**
13. Birthplace **Wisconsin**
14. Maiden name **Emily Cook**
15. Birthplace _____

Other conditions (include pregnancy within 3 months of death) **1041**
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER {
16. (a) Informant's own signature **Thornie Fife**
(b) Address **Rockwood Mo**
17. (a) **Burial** (b) Date thereof **JAN-16-40**
(c) Place: burial or cremation **Cedar Hill Mo**
18. (a) Signature of funeral director **Charles Lee**
(b) Address **James E. Lee 920**
19. (a) **2-1-40** (b) **J. M. Green**

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **2-15**
While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature **J. Ward Thomas** (Mr. D. or other) **5**
Address **Greenfield Mo** Date signed _____

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

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.