

BUREAU OF THE CENSUS  
NOV 20 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35897

Registration District No. 604

Primary Registration District No. 4358

Registrar's No.

1. PLACE OF DEATH:

(a) County new Madrid  
(b) City or town new Madrid  
(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 2  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME CLAY W. DANSON  
3. (b) If veteran, name war no  
3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced divorced  
6. (b) Name of husband or wife Betty Ellis Dawson  
6. (c) Age of husband or wife if alive 26 years  
7. Birth date of deceased Dec 26 1863  
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 8  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation justice of peace

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

MOTHER FATHER  
12. Name George Dawson  
13. Birthplace new Madrid MO  
(City, town, or county) (State or foreign country)  
14. Maiden name Amanda Stubble  
15. Birthplace new Madrid MO  
(City, town, or county) (State or foreign country)

16. (a) Informant Ms. Hal Heintze  
(b) Address new Madrid MO

17. (a) Burial (b) Date thereof Oct 6 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation new Madrid Moberguez

18. (a) Signature of funeral director L. Richardson

(b) Address new Madrid MO

19. (a) 10/23/40 (b) Wm O. Bann  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County new Madrid  
(c) City or town new Madrid  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 4 day 4  
year 1940 hour 2:30 P minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Sept 20, 1940, to Oct 4, 1940  
that I last saw him alive on Oct 4, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Myo. Quadriceps

Due to hypertension

Due to \_\_\_\_\_  
Other conditions Quadriceps Sclerotic  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
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? \_\_\_\_\_

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

23. Signature W. O. Bann (M. D. or other) \_\_\_\_\_  
Address new Madrid MO Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 2,

District File Number 1140-162

Date Filed 11/1/40

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**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.**