

STANDARD CERTIFICATE OF DEATH

Registration District No. 470

Primary Registration District No. 3733

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Lawrence
 (b) City or town Mt. Vernon, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Missouri State Sanatorium
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 385 days
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade
 (c) City or town Everton
 (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 Offner Daigh

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

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

6. (b) Name of husband or wife Sylvia Shane Daigh
 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased June 24th 1894
 (Month) (Day) (Year)

8. AGE: Years 46 Months 10 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Albert W. Daigh

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

14. Maiden name Stella Shelton

15. Birthplace Dade County Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk

(b) Address Missouri State Sanatorium

17. (a) Removal (b) Date thereof April 30-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenfield, Mo.

18. (a) Signature of funeral director J. W. Ward
 (b) Address Greenfield, Mo.

19. (a) 4-28-1941 (b) P.A. Holmes
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28th
 year 1941 hour 10:25 minute A M.

21. I hereby certify that I attended the deceased from April 9, 1940, to April 28, 1941.

that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis About 22 months Duration

Due to _____

Due to _____

Other conditions 128
 (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy Pulmonary Tuberculosis

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? _____

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

23. Signature J. W. Ward (M. D. or other) J. W. D.

Address Mt. Vernon, Mo. Date signed 7/28/41

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

MOTHER FATHER

RECEIVED

District Health Officer No. 61

District File

Date Filed

541-725
MAY 7 1949

JAN 20 1949

B. 'CK' IAK - IVKE Y BEN A MEAL RECORD

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. W. Ward*

Licensed Embalmer No. *2832*

P. O. Address *Greenfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

TABLE 61

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7852

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15029

Registration District No. 470

Primary Registration District No. 5633

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laurence
(b) City or town St. Vermont, P.
(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)

3. (a) PRINT FULL NAME Offner Daigle
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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased June - 24 - 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 10 4 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-28-1941 (b) P.A. Holmes
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Apr day 28
year _____ hour _____ minute _____ M.

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 _____ Duration _____

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? _____

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

23. Signature D.S. Coffman (M. D. or other) _____

at St. Vermont Date signed _____

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

SUPPLEMENTARY

