

No. 2
1-4-41
-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38639**

DEC 16 1941
449

Registration District No. _____

Primary Registration District No. **4267**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **LACLEDE**
(b) City or town **LEBANON Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **WALLACE Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether
In this community **ALWAYS**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **LACLEDE 53**
(c) City or town **Roby**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **DWAYNE ELMORE**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **M U** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **SINGLE**

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

7. Birth date of deceased **OCT. 23 1934**
(Month) (Day) (Year)

8. AGE: Years **7** Months _____ Days **20** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name **DEWITT ELMORE**

13. Birthplace **Roby OMO**
(City, town, or county) (State or foreign country)

14. Maiden name **ANNIE EASLEY**

15. Birthplace **TEXAS CO OMO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dewitt Elmore**

(b) Address **Roby Mo**

17. (a) **BURIAL** (b) Date thereof **11 14 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Roby**

18. (a) Signature of funeral director **PALMERS**

(b) Address **LEBANON Mo**

19. (a) **11-14-41** (b) **J. M. Lamb**
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV** day **12**
year **1941** hour **2** minute **A. M.**

21. I hereby certify that I attended the deceased from **Oct. 20-41**
19____ to **Nov. 12** 19**41**

that I last saw h. i. m. alive on **Nov. 12** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho-Pneumonia**

Due to **Pertussis**

Due to _____

Other conditions **acute Endocarditis**
(Include pregnancy within 3 months of death)

Major findings: Of operations **9**

Of autopsy _____

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? **2**

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

23. Signature **Poland E. Gaston** (M. D. or other) **P. O.**

Address **Roby Mo** Date signed **11-13-41**

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

MOTHER FATHER

404 (Licensed Embalmer's Statement on Reverse Side)

Laclede County Unit

Co. File # 12-41-12

Date Filed 12-11-41

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

Alyn DeRose

....., Registered Apprentice No. 294

working under my personal supervision.

Signed

R. DeRose

Licensed Embalmer No. 1161

P. O. Address St. Louis 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.