No. 2
1-4-41
17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 21 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29748

Registration District No. 38 — Primary Registration District No. 3006-5120 — Registrar's No. 185

1. PLACE OF DEATH:

(a) County: BOONE

(b) City or town: COLUMBIA (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: THE ELLIS FISCHEL STATE CANCER HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 5 DAYS (Specify whether years, months or days)

In this community: 5 DAYS

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: SALINE

(c) City or town: MARSHALL (If outside city or town limits, write "RURAL")

(d) Street No.: SOUTH OLSEN (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country: —

3. (a) PRINT FULL NAME: HIRAM A. DIAL

3. (b) If veteran, name war: —

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: RUTH WILSON

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: JANUARY (Month) 29 (Day) 1869 (Year)

8. AGE: Years 73 | Months 7 | Days 0 | If less than one day: hr. min.

9. Birthplace: COOPER (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation: LABORER

11. Industry or business: —

FATHER

12. Name: JOHN DIAL

13. Birthplace: COOPER (City, town, or county) MISSOURI (State or foreign country)

MOTHER

14. Maiden name: LAURA ?

15. Birthplace: COOPER (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant: PT. (HIRAM A. DIAL)

(b) Address:

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

(c) Place: burial or cremation: Columbia

18. (a) Signature of funeral director: [illegible]

(b) Address: Columbia, Mo.

19. (a) 8-29-42 (Date received by local registrar) (b) Edna H. Burlew (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 29 year 1942 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from AUGUST 24, 1942, to AUGUST 29, 1942; that I last saw him alive on AUGUST 29, 1942, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of lip with metastasis to cervical lymph nodes	7 M
Due to:	
Due to: Bronchopneumonia	about 7 days
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: Metastatic carcinoma cervical nodes	

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: F. V. Ackerman (M. D. or other) M.D.

Address: Ellis Fischel State Cancer Hospital Date signed 8/29/42

12 50 (Licensed Embalmer's Statement on Reverse Side)

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 wi the above constitutes grounds for revocation of license.)

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

S. No. 2B
M—8-21-41
No. I X20288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29748

Registration District No. 38 Primary Registration District No. 3056 Registrar's No. 185

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

1. PLACE OF DEATH:

(a) County: Reave

(b) City or town: Columbia

(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME: Hiram A. Dial

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: D

6. (b) Name of husband or wife

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

7. Birth date of deceased: Jan (Month) 29 (Day) 1869 (Year)

8. AGE: Years 73 Months 7 Days 8 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) Removal (Burial, cremation, or removal) (b) Date thereof 8 29 42 (Month) (Day) (Year)

(c) Place: burial or cremation: Sedalia

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 29 year 1942 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY