

No. 2
-17-
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 15 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32570
State File No. 32070
Registrar's No. 83

Registration District No. 200

Primary Registration District No. 2722-

Registrar's No. 83

1. PLACE OF DEATH:

(a) County MACON
(b) City or town Hudson Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Il - Mildred Hos.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John De Vries

3. (b) If veteran, name war no 3. (c) Social Security No. 210

4. Sex Male 5. Color or race White 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 April 5 1893
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____
12. Name John De Vries
13. Birthplace Holland
(City, town, or county) (State or foreign country)
14. Maiden name Andrewa Bloom
15. Birthplace Holland
(City, town, or county) (State or foreign country)

16. (a) Informant Henry De Vries
(b) Address Green City Mo
17. (a) removal (b) Date thereof Sept 16 - 43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Il - Mildred Hos

18. (a) Signature of funeral director Glenn E. Kutt + Son
(b) Address Green City Mo
19. (a) 9/15/43 (b) John B. Hunkler
(Date received local registrar) (Registrar signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Sullivan
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Union Trp
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6
year 1943 hour 7 minute 25 A.M.
21. I hereby certify that I attended the deceased from Aug 20, 1943 to Sept 6, 1943
that I last saw him alive on Sept 5, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis

Due to Toxic Psychosis Duration 2 Months

Due to _____

Other conditions (Include pregnancy within 3 months of death) 838

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) _____ (e) Means of injury _____

23. Signature J. M. Still (M. D. or other) _____
Address macon mo Date signed Sept 17 43

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number OCT 14 1943-1705

Date Filed OCT 11 1943

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Grew City, Me

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.