

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 10 1946 STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8548**

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 315

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sunny Slope Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Da (Specify whether years, months or days)
In this community 1 Da

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County De Kalb
(c) City or town Maysville
(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 Donald Wayne Dyas

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

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: Oct 10 1943
(Month) (Day) (Year)

8. AGE: Years 2 Months 5 Days 4 If less than one day hr. _____ min. _____

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

10. Usual occupation At Home

MOTHER FATHER
11. Industry or business _____
12. Name John D. Dyas
13. Birthplace Clarksdale Mo
(City, town, or county) (State or foreign country)
14. Maiden name Francis Ruth Rhoades
15. Birthplace Stewartsville Mo
(City, town, or county) (State or foreign country)

16. (a) Informant J. D. Dyas
(b) Address Maysville, Mo.

17. (a) Removed (b) Date thereof 3-15-46
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Fleeman & Son Inc.

(b) Address St Joseph Mo.

19. (a) Mar. 19, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature) V.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 14 year 1946 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from March 13 1946 to March 14 1946 that I last saw him alive on March 14 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Laryngeal Diphtheria, 4da
Meningococci, Diptheritic
Due to _____ Duration 4da

Due to _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: Laryngeal Obstruction PHYSICIAN _____
Of operations _____ Underline the cause to which death should be charged statistically.
Of autopsy 10

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 plane) _____
While at work? _____ Means of injury _____
23. Signature W. Roy Moore (M. D. or other) MD
Address St Joseph Mo Date signed 3/15/46

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

7480

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

Robert G. Gyle

Licensed Embalmer No.

3308

P. O. Address

St. Joseph, 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.