

No. 2
-243
5-17-39
X3887

FILED MAR 28 1947
Registration District No. **219**

Primary Registration District No. **4330**

Registrar's No. **13**

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

1. PLACE OF DEATH:
 (a) County Mississippi
 (b) City or town East Prairie
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Residence
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 3 years
 years, months or days

3. (a) PRINT FULL NAME HENRY C. DALE
3. (b) If veteran, name war _____ **3. (c) Social Security** No. None

4. Sex Male **5. Color or race** White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Beatrice Dale **6. (c) Age of husband or wife if alive** 53 years
7. Birth date of deceased July 18, 1891
 (Month) (Day) (Year)

8. AGE: Years 55 Months 7 Days 1 If less than one day _____ yr. _____ min.
9. Birthplace Pleasanton, Iowa
 (City, town, or county) (State or foreign country)

10. Usual occupation welder ✓

11. Industry or business
12. Name John Dale
13. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)
14. Maiden name Mary Kavanaugh
15. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Beatrice Dale

(b) Address East Prairie, Mo.

17. (a) Burial (b) Date thereof 2-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Pk. Marianne

18. (a) Signature of funeral director James Shelby

(b) Address East Prairie, Mo.

19. (a) 3-7-47 (b) Beatrice E. Harper
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Mississippi
 (c) City or town East Prairie, Mo.
 (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 19
 year 1947 hour 9.15 minute _____ P. M.
21. I hereby certify that I attended the deceased from Feb 19
1947 to Feb 19 1947
 that I last saw him alive on Feb 19 1947
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Coronary Occlusion 30 min
 Due to arterio-sclerotic
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy 94A
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)
 Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature D. O. Martin (M. D. or other)
 Address East Prairie Date signed 2/21/47

RECEIVED
District Health Office 718
District File Number 347-423
Date Filed 3-25-47

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 *Frank Shelby*.....

Licensed Embalmer No. *2726*.....

P. O. Address *East Prairie, 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.

April 13

Registration District No. *218*

Primary Registration District No. *4330*

Registrar's No.

1. PLACE OF DEATH:

(a) County *Mississippi*
(b) City or town *East Prairie*
(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 *Henry C. Dale*

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 _____

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years *55* Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business *Welder*

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) *Esther G. Harper* (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 *Feb* Year *1947* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 work? _____ (Specify type of place) (e) Means of injury _____

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

Date signed _____

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

SUPPLEMENTARY

10043