

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29955

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 120 PRIMARY REG. DIST. NO. 5465 Registrar's No. 878

1. PLACE OF DEATH a. COUNTY <u>Green</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u>	
b. CITY (If outside corporate limits, write RURAL and give township and county) OR TOWN <u>Springfield</u>		b. COUNTY <u>Green</u>	
c. CITY (If outside corporate limits, write RURAL and give township and county) OR TOWN <u>Springfield - N. Campbell</u>		c. CITY (If outside corporate limits, write RURAL and give township and county) OR TOWN <u>Springfield - N. Campbell</u>	
d. FULL NAME OF (If in hospital or institution, give street address of location) HOSPITAL OR INSTITUTION <u>R.F.D. - 2 - Box 102</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.D. - 2 -</u>	

3. NAME OF DECEASED (Type or Print) <u>MATTIE</u>	a. (First)	b. (Middle)	c. (Last) <u>DALTON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct - 1 - 1949</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar - 6 - 1877</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (of the kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (State or foreign country) <u>Wright Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Henry Minns</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Hayes Dalton</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hayes Dalton - R.F.D. 2</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy</u>		MEDICAL CERTIFICATION RELATIONSHIP BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Aug 15, 1949, to Oct 1, 1949, that I last saw the deceased alive on Sept 29, 1949, and that death occurred at 4:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Leman R. Brown, M.D.</u>	23b. ADDRESS <u>311 1/2 Boonville Springfield, Mo.</u>	23c. DATE SIGNED <u>Oct. 5, 1949</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-4-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Marshfield Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Marshfield Mo</u>
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DATE REC'D BY LOCAL REG. <u>10-5-49</u>	REGISTRAR'S SIGNATURE <u>W.E. Haydley</u>	25. FUNERAL DIRECTOR'S SIGNATURE (ADDRESS) <u>Herbert Y. Smith, 602 N. Jefferson</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6751 ' ' 100

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Herbert V. Smith*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*4286*

P. O. Address \_\_\_\_\_

*Springfield*

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.