

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5519

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 383 PRIMARY REG. DIST. NO. 5655 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mt. Vernon</u>		c. LENGTH OF STAY (in this place) <u>15 days</u>	c. CITY OR TOWN <u>Webb City</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mo. State Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>Jasper County Tuberculosis Hospital</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Floyd</u>	b. (Middle) <u>Elmer</u>	c. (Last) <u>Dell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 15, 1956</u>
-------------------------------------	-------------------------	--------------------------	-----------------------	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 10, 1917</u>	9. AGE (In years last birthday) <u>39</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus driver, farmer, insurance</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Eagle Rock, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	---	---	---

13a. FATHER'S NAME <u>George Franklin Dell</u>	13b. MOTHER'S MAIDEN NAME <u>Iva May Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Clara Dell</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes 1942 to 1945</u>	16. SOCIAL SECURITY NO. <u>544-05-2295</u>	17. INFORMANT'S SIGNATURE OR NAME <u>San records, Mo. State San., Mt. Vernon, Mo.</u>	ADDRESS _____
--	--	---	---------------

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cor Pulmonale</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	ANTECEDENT CAUSES DUE TO (b) <u>Bronchopleural fistula &amp; empyema</u>		<u>unknown</u>
	DUE TO (c) <u>Pulmonary Tuberculosis</u>		<u>over 10 years</u>
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 checked="" type="checkbox"/>
------------------------------	--	--

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) _____
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
--	--	----------------------------------

22. I hereby certify that I attended the deceased from 2 - 1 - 1956, to 2 - 15 - 1956, that I last saw the deceased alive on 2 - 15 - 1956, and that death occurred at 11:10 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>John W. Park, MD</u> (Degree or title)	23b. ADDRESS <u>Mt. Vernon, Mo.</u>	23c. DATE SIGNED <u>2-16-56</u>
--	-------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVABLE</u>	24b. DATE <u>2-15-56</u>	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) <u>Cassville, Mo.</u>
--	--------------------------	--	---

DATE REC'D BY LOCAL REG. <u>2-16-56</u>	REGISTRAR'S SIGNATURE <u>Paul D. Herbert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul D. Herbert</u>	ADDRESS <u>Cassville, Mo.</u>
---	--	---	-------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 26 1952

1958

MAR 2

MAY 31 1962

==

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..

Student.....  
Signature of Student Embalmer

Signed *Paul D. Kenbest*.....

Licensed Embalmer No. *457*

P. O. Address *Cassville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.