

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024967
STATE FILE NUMBER

AMENDED FILED JUL 24 1961 Primary Registration District No. 3025 Registrar's No. 100

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Norfolk</u>		2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Norfolk</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Length of stay in lb <u>20 yrs</u>	c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>519 Railroad</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>519 Railroad</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Wm Sn. Dallen</u>		4. DATE OF DEATH <u>6/26-61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18-1877</u>
9. AGE (last birthday) <u>69</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Norfolk, Mo. U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Neville Dallen</u>	
13b. MOTHER'S MAIDEN NAME <u>Dorcasia Rose</u>		14. NAME OF HUSBAND OR WIFE <u>Geoph Dallen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mr Wm Dallen</u>		Address <u>West Plains Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>
DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u>			
DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>① HYPERTENSION, ESSENTIAL</u> <u>② HYPERTENSIVE Cardio-Vascular Dis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>Oct. 14 1935</u> to <u>6-26-61</u> and last saw him alive on <u>6-26-61</u> Death occurred at <u>9:20 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Joseph W. Wilson, M.D.</u>		22b. ADDRESS <u>West Plains, Mo</u>	
22c. DATE SIGNED <u>7-5-61</u>			
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE <u>7-29-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Traylor</u>	23d. LOCATION (City, town, or county) (State) <u>Pomona Mo</u>
24. FUNERAL DIRECTOR <u>Kahler</u>	ADDRESS <u>West Plains Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-17-61</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

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 *A. A. Roberts*

Licensed Embalmer No. 3437

P. O. Address *Leesville*

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.