WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X14028

REC'D APR 11 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11462
Do not use this space.

1. PLACE OF DEATH
(a) County Livingston Registration District No. 508
(b) Township Primary Registration District No. 3026 Registered No. 44
(c) City Chillicothe (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 254 Elizabeth McNally
(a) Residence, No. Locust St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marquis McNally
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 20-1882
7. AGE YEARS 56 MONTHS 3 DAYS 6 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Princeton Mo.

FATHER
13. NAME Green Williams
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Platt Co. Mo.

MOTHER
15. MAIDEN NAME Isadora Norris
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa.

17. INFORMANT (ADDRESS) Mrs. Etta Bryan Chillicothe Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Anderson Cem DATE Mar-29-1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) James D. Gordon Chillicothe, Mo.
20. FILED 3-27- 1939 Donald H. Dowell M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 26 1939
22. I HEREBY CERTIFY, That I attended deceased from — 1935 to March 26 1939
I last saw her alive on Mar 23 1939 Death is said to have occurred on the date stated above, at 7:15 a m.
The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis

Date of onset

Other contributory causes of importance: 23

Name of operation Clinical Date of
What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) R. J. Kaufman, M. D.
(Address) Chillicothe, Mo.

456

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number 39-208
Date Filed APR 6 1939

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, James D Gordon, or by —,

Registered Apprentice No. —, working under my personal supervision.

Signed James D Gordon

Licensed Embalmer No. 1870

P. O. Address Chillicothe 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, above space should be left blank.