

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

12652
 Do not use this space.

REC'D APR 18 1939

1. PLACE OF DEATH *Verwon*

(a) County *Verwon* Registration District No. *875*

(b) Township *Washington* Primary Registration District No. *1167*

(c) City *Nevada* (d) Street No. *State St. #3* St. *Nevada*

(e) Length of residence in city or town where death occurred *13 yrs. 11 mos. 19 ds.* (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Chas. Mc Dill*

(a) Residence, No. *Kansas City, Mo.* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1874*

7. AGE YEARS *65* MONTHS *?* DAYS *?* If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Musician*

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) *OK* 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Brookfield Mo.*

13. NAME *Chas W Mc Dill*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*

15. MAIDEN NAME *Morning Curtis*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Iowa*

17. INFORMANT (ADDRESS) *Hoop. Records*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3/13 1939*

I HEREBY CERTIFY, That I attended deceased from *Jan 1st* 19*39*, to *Mar 13* 19*39*

I last saw him alive on *3/13* 19*39* Death is said to have occurred on the date stated above, at *5:40 pm.*

The principal cause of death and related causes of importance were as follows:
Myocardial Insufficiency & Cardiac dilatation

Date of onset *OK*

Other contributory causes of importance: *92 W*

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) *J. Hopkins* _____, M. D.
Nevada Mo (Address) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE *Kansas City* DATE *3-14* 19*39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Wm. Newcomer*
Kansas City Mo

20. FILED *3-14* 19*39* *Allen W. Days*
 Local Registrar. *875*

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 X18605

MAY 16 1945

RECEIVED
District Health Officer No. 7
District File Number 7-39-637
Date Filed 4-17-39

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.....

Licensed Embalmer No.....

P. O. Address.....

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.