

REC'D MAY 24 1939

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

16352
Do not use this space.

1. PLACE OF DEATH *Texas* 2
(a) County *Texas* Registration District No. *866*
(b) Township *Current* Primary Registration District No. *6146* Registered No. _____
(c) City _____ (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.
235

2. PRINT FULL NAME *Sarah McDaniels*
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Timothy McDaniels*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 21 - 1873*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 5 25

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-15* 19 *39*
22. I HEREBY CERTIFY, That I attended deceased from *4/15* 19 *39*, to _____ 19____
I last saw him alive on *4-15* 19 *39*. Death is said to have occurred on the date stated above, at *noon*
The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia 4-12-39
Date of onset

Other contributory causes of importance:
Uterine Cancer
Uterus

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? _____
If so, specify _____
(Signed) *Dr. J. M. Reedon* M.D.
Summersville (Address)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Hartsville, Mo.*
13. NAME *Daniel O. Gudkovs*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill.*
15. MAIDEN NAME *Armanda Buckner*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*
17. INFORMANT (ADDRESS) *John Murphy, Hartsville, Mo.*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Antioch* DATE *4-18* 19 *39*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Pear Lewis, Licking, Mo.*
20. FILED *4-15* 19 *39* *Maggie E. Murphy* Local Registrar

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.

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.