

REC'D SEP 12 1939

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

28661
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan Registration District No. 85
(b) Township _____ Primary Registration District No. 1001 Registered No. 892
(c) City St. Joseph (d) Street No. Mo. Math. Hospital 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 Robert E. McDaniel
(a) Residence, No. 2633 Jules St. (If nonresident, give city, or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary McDaniel
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 29th 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 2 1
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. Resturant Operator
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) Hemple Mo.

FATHER
13. NAME Robert McDaniel
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hemple Mo.

MOTHER
15. MAIDEN NAME Margaret Kerns
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hemple Mo.

17. INFORMANT (ADDRESS) Mrs. Geo Kirwan
2904 Felix St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Auburn DATE Aug. 31st 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON, INC.
1946 Calhoun St. Joseph, Mo.

20. FILED 8/30 39 A. J. Westlich
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 30th 1939
22. Aug 30th 1939 I HEREBY CERTIFY, That I attended deceased from viewed 19... to 19...
I last saw ~~#####~~ 19... Death is said to have occurred on the date stated above, at 6:30 AM

The principal cause of death and related causes of importance were as follows:
Internal injuries received when thrown from an Auto Date of onset _____

Other contributory causes of importance: none

Name of operation _____ Date of _____
What test confirmed diagnosis? History Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 8/29 1939
Where did injury occur? St. Joseph, Mo. (Specify city of town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
Public place
Manner of injury Crushed by auto
Nature of injury Internal injuries (Abdomen)

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify (Address) B. W. Tadlock Coroner, M. D.
King Hill Bldg

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.

2108-

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. ~~1448~~

working under my personal supervision.

Signed: *Wm J. Fleeman*

Licensed Embalmer No. *1448*

P. O. Address. *St. Joseph, 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28661
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
(b) Township _____ Primary Registration District No. 1001
(c) City St Joseph (d) Street No. _____ Registered No. 892
(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

Robert E. McDaniel
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH ³⁰

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 20, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

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

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
69 2 1

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc.
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

Internal injuries re-
ceived when thrown from
an auto Was attempting to
recover
another driverless car
Date of onset 2/10/39

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

Name of operation _____ Date of _____
What test confirmed diagnosis? History Was there an autopsy? _____

13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide Accident Date of injury 8/20, 1939
Where did injury occur? St Joseph, Mo.
(Specify city or town, county, and State)

15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

Specify whether injury occurred in industry, in home, or in public place.
Public place
Manner of injury Crushed by auto
Nature of injury Internal injuries

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____ (Signed) B. W. Tadlock, M. D.
(Address) St Joseph Mo

Local Registrar.

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

S-28661