

REC'D SEP 19 1939

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

29693
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547
 (b) Township Mason Primary Registration District No. 303
 (c) City Hannibal (d) Street No. Lexington Hospital Registered No. 229
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 Beland Daniels

(a) Residence, No. 612 Hill 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 Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May-24-1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
Stillborn - - -

OCCUPATION 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.
 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) Hannibal Mo

FATHER 13. NAME Joseph Daniel

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hannibal Mo

MOTHER 15. MAIDEN NAME Fulta Foster

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saxton Mo

17. INFORMANT (ADDRESS) Rebecca McCullin 612 Hill St. Hannibal, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Graceland Burial Park DATE May-25-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) James O'Donnell Hannibal, Mo

20. FILED Aug 8 1939 J. C. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-24-1939

22. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to..... 19.....

I last saw h..... alive on..... 19..... Death is said

to have occurred on the date stated above, at 9 P. m.

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

Stillbirth

Other contributory causes of importance:

Syphilitic

Name of operation None 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) B. S. Murphy M. D.

(Address) Hannibal, Missouri

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 Michael J. G. Donnell

Licensed Embalmer No. 3246

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

29693

Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547
(b) Township _____ Primary Registration District No. 3029
(c) City Hannibal (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.

Registered No. 229

2. PRINT FULL NAME Leland Daniels

(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

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 8

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 24, 1937

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

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

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

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. _____

10. Date deceased last worked at this occupation (month and year) _____

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

Date of onset _____

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

Other contributory causes of importance: _____

13. NAME Joseph Daniels

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

Name of operation _____ Date of _____

15. MAIDEN NAME _____

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

16. 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? _____ Date of injury _____, 19____

17. INFORMANT (ADDRESS) _____

Where did injury occur? _____ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS) _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) B. G. Murphy, M. D.

20. FILED Oct 10, 1937 E. M. Leedy

(Address) Hannibal Mo

Local Registrar.

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.

SUPPLEMENTARY

