

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.

REC'D NOV 7 1939

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **36883**

Registration District No. 665 Primary Registration District No. 5885 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Houstonia (Township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pettis  
(c) City or town Houstonia Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Mary O McKinley

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife W. O. McKinley 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 24 1848  
(Month) (Day) (Year)

8. AGE: Years 91 Months 1 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Saline Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business \_\_\_\_\_

12. Name William M. Taylor

13. Birthplace Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Ann Hunt

15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs W. O. McKinley

(b) Address Houstonia

17. (a) burial (b) Date thereof Oct 18, 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Grange

18. (a) Signature of funeral director W. D. Brook

(b) Address Houstonia Mo.

19. (a) Oct. 18 '39 (b) Mrs. J. B. Norsey  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. 16 day \_\_\_\_\_ year 1939 hour 7:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Oct 15 to Oct 15, 1939; that I last saw him alive on Oct 15, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Exhaustion

Due to Paralysis of muscles of deglutition  
Due to age

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations X

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. D. Brook (M. D. or other) \_\_\_\_\_  
Address Houstonia, Mo. Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Sold

1939  
+astroquid vte

RECEIVED  
District Health Officer No. 8  
District File Number 116739  
Date Filed 11/6/39

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

Signed H. W. Smiley  
Licensed Embalmer No. 3987  
P. O. Address Houston, 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

36883  
Do not use this space.

1. PLACE OF DEATH

(a) County Pettis Registration District No. 665  
 (b) Township Assustonia Primary Registration District No. 3883 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. da (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Mary O. Finley

(a) Residence, No. \_\_\_\_\_ (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
91 1 22

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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 16 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 \_\_\_\_\_ m.

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

Paralysis of muscles of respiration - cerebral effusion  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: g. i. l.

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 C. L. Parschurst, M. D.

(Signed) \_\_\_\_\_ (Address) Assustonia

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

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

SUPPLEMENT

