

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.

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

Do not use this space.

37432

1. PLACE OF DEATH

County Oregon Registration District No. 1077
 Township Carroll Primary Registration District No. 6140
 City Summersville No. _____ St. _____ Ward _____

File No. _____
 Registered No. 14

2. FULL NAME

Adeline McDaniel
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OR (OR) WIFE OF <u>Thos. H. McDaniel</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>9-29-1857</u>		
7. AGE YEARS <u>88</u>	MONTHS <u>-</u>	DAYS <u>19</u>
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as silk mill, 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) <u>Pikeville Tenn</u>		
MOTHER FATHER	13. NAME <u>Joel Penduroast</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>	
	15. MAIDEN NAME <u>Don't know</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>	
17. INFORMANT (ADDRESS) <u>J. B. McDaniel, MD, Summersville, Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Willard, Mo</u> DATE <u>10-6-39</u>		
19. UNDERTAKER (ADDRESS) <u>Greenwald Funeral Home, Summersville, Mo</u>		
20. FILED <u>Oct. 20, 1939</u> <u>J. B. McDaniel, MD</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-18-1939

22. I HEREBY CERTIFY, That I attended deceased from 10-12-1939 to 10-18-1939.
 I last saw her alive on 10-15-1939. Death is said to have occurred on the date stated above, at 7 A.
 The principal cause of death and related causes of importance were as follows:
Fracture of left hip - accidental
 Date of onset _____

Other contributory causes of importance:
Senility

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~~ ~~homicide~~? _____ Date of injury 10-12-1939
 Where did injury occur? at home
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury fall in home
 Nature of injury Fracture of left hip

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) E. R. Terwill M. D.
 (Address) Cent. View

RELEASED

Department Health Officer No. 5.

D. Number 118394

Date Filed 11839