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.

DEC 5 [illegible]

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

40094
Do not use this space.

1. PLACE OF DEATH
(a) County Lafayette 2 Registration District No. 464
(b) Township Mid Bar 1 Primary Registration District No. 5627 Registered No. 52
(c) City Odessa (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.

2. PRINT FULL NAME 264 Francis McGirl
(a) Residence, No. Odessa Mo. St. ☐
(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 Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 14-1939
7. AGE YEARS 0 MONTHS 0 DAYS 0 If LESS than 1 day, ... hrs. or ..... min.

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) Odessa Missouri

FATHER
13. NAME Keles McGirl
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mayview Mo.

MOTHER
15. MAIDEN NAME Francis C. Sherrow
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wellington Mo.

17. INFORMANT (ADDRESS) Keles McGirl Mayview - Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Greenton DATE Nov 14 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Blinson & Son Odessa Mo.
20. FILED Nov-14 1939 Mrs E. M. Goodwin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 14 1939
22. I HEREBY CERTIFY, That I attended deceased from Dead Fetus, 19..., to ....., 19.....
I last saw h..... alive on born Dead, 19..... Death is said to have occurred on the date stated above, at 2 p m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Dead Fetus	
born Dead.	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Obs 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? .....
If so, specify .....
(Signed) Dr J. C. Beltram M.D.
(Address) Wellington Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Filed 10/6/39

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 .....

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 compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.