

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FILED FEB 5 1940

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

3523
Do not use this space.

1. PLACE OF DEATH
 (a) County Pike Registration District No. 750
 (b) Township Doniphan Primary Registration District No. 4451
 (c) City Doniphan (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 Emma McRae
 (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

3. SEX Female 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 George McRae
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 25 - 1899
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 10 15
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) Randolph Co. Illinois
 FATHER 13. NAME Wright
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 MOTHER 15. MAIDEN NAME Sarah Owens
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) George McRae
 18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Ridge DATE 1-10 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dish
 20. FILED Jan. 10, 1940 E. B. Johnson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 9, 1940
 22. I HEREBY CERTIFY That I attended deceased from April 25, 1938, to January 8, 1940
 I last saw him alive on May 17, 1939. Death is said to have occurred on the date stated above, at 8:05 P.M.
 The principal cause of death and related causes of importance were as follows:
Mycocarditis
 Date of onset Jan 1
 Other contributory causes of importance: Arthritis
 Name of operation none Date of _____
 What test confirmed diagnosis? clinical 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) J. P. Williams, M. D.
 _____ (Address) Doniphan, Mo

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.

RECEIVED

District Health Officer No. 5;

Signed.....

District File Number 140135

Licensed Embalmer No.....

Case Filed 13140

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.