V. S. No. 2
M—11-10-39
ev. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 5959

Registrar's No. 160

11
5
7

1. PLACE OF DEATH:

(a) County Buchanan,

(b) City or town St. Joseph, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days, (Specify whether

In this community 3 days, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan,

(c) City or town Grant City, Missouri, (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Deva May Maylan Daniels, 542

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 Married

6. (b) Name of husband or wife Woodrow V. Daniels,

6. (c) Age of husband or wife if alive 288 years

7. Birth date of deceased September (Month) 12th (Day), 1914 (Year)

8. AGE:

Years	Months	Days	If less than one day
25	5	1	hr. min.

9. Birthplace Grant City, (City, town, or county) Missouri, (State or foreign country)

10. Usual occupation At Home,

11. Industry or business

FATHER
12. Name Arthur Maylan, 0
13. Birthplace Grant City, (City, town, or county) Missouri, (State or foreign country)

MOTHER
14. Maiden name Effie Wyman,
15. Birthplace Gentry Co. (City, town, or county) Mo. (State or foreign country) 0

16. (a) Informant Woodrow V. Daniels

(b) Address Grant City, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 13, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation removal, Grant City, Mo.

18. (a) Signature of funeral director Norton Bridale & Bowman Funeral

(b) Address 319 S. 10th. Str. Home

19. (a) Feb. 13, 1940 (Date received local registrar) (b) H J Nesthabash (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb'y day 13th year 1940 hour 6 minute a M.

21. I hereby certify that I attended the deceased from Feb 10 Feb 10, 1940, to Feb 13, 1940 that I last saw her alive on Feb 13, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Streptococcic meningitis	2-9-40
Due to	
Due to 140	
Other conditions Naso Pharyngitis (Include pregnancy within 3 months of death) Spontaneous abortion	
Major findings: Of operations None	
Of autopsy None	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

85

23. Signature E. M. Shores (M. D. or other) 1

Address 317 Kirkpatrick Bldg St. Joseph Mo. Date signed 2-13-40

(Licensed Embalmer's Statement on Reverse Side)

AUG 19 1958

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 Wm E. Summerfield

Licensed Embalmer No. 3007

P. O. Address 369 So. St Joseph 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.