

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 4267

Primary Registration District No. 4267

Registrar's No. _____

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEBANON
(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 40 year
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE
(c) City or town LEBANON
(If outside city or town limits, write "RURAL")
(d) Street No. HAYS ADDITION
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME MARY GAYNE O'NEAL 540

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife JOHN O'NEAL 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased SEPT 15 1855
(Month) (Day) (Year)

8. AGE: Years 84 Months 5 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace BERNERSVILLE W. VA 1
(City, town, or county) (State or foreign country)

10. Usual occupation Home wife

11. Industry or business _____

MOTHER FATHER { 12. Name Ant H 9
13. Birthplace _____ (City, town, or county) (State or foreign country)

{ 14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rosa Osher
(b) Address Lebanon Mo

17. (a) BURIAL (b) Date thereof 2-21-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation LEBANON MO

18. (a) Signature of funeral director Palmer 404
(b) Address Lebanon, Mo

19. (a) 2-20-1940 J. A. M. Coult
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 20
year 1940 hour 2 minute 27 A. M.

21. I hereby certify that I attended the deceased from 2/14/1940 to 2/18/1940,
that I last saw her alive on 2/18/40
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage

Due to Ch. Pulmonary TB e

Due to Arterio-Sclerosis

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 23

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 Wm J. Wilhays (M. D. or other) (M.D.)
Address Lebanon Date signed 2/20/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED
District Health Officer No. 7,
District Health Number 3-116-1191
Date Filed 3-14-40

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 *W. A. Palmer*
Licensed Embalmer No. 1161
P. O. Address *Litton 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.