

FILED APR 4 1940

Registration District No. 417

Primary Registration District No. 3021

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Jasper  
 (b) City or town Webb City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution 15 1/2 South Main  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2  
(Specify whether years, months or days)  
 In this community 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
 (c) City or town Webb City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 15 1/2 S Main  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME

MARY Mc DONALD

8. (b) If veteran, name war

None

8. (c) Social Security No.

None

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife None

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

7. Birth date of deceased May 17 1875  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>9</u>	<u>16</u>	hr. _____ min.

9. Birthplace Sedalia  
(City, town, or county)

MO  
(State or foreign country)

10. Usual occupation Sales lady

11. Industry or business Cosmetics

12. Name James Mc Donald

13. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Mc Donald

15. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Mrs. Susan Lyons

(b) Address St Louis Mo

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof Mar 5 1940  
(Month) (Day) (Year)

(c) Place: burial or cremation St Hope Cem

18. (a) Signature of funeral director Hedget Nelson

(b) Address Webb City Mo

19. (a) MO. 5. 40 (Date received local registrar) (b) J. P. Critchfield MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3  
 year 1940 hour 7:30 minute 9 M.

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

Immediate cause of death Acute Indigestion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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? 377 (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. B. Munson (M. D. or other) D. O.

Address Webb City, Mo Date signed 3-4-40

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

118c

*Munson*

RECEIVED FILED STATE OFFICE  
INDEX CARD RETURNED TO DISTRICT  
DATE APR 8 1946

**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.....

*C. N. Hedger*

Registered Apprentice No. 2859

working under my personal supervision.

Signed *C. N. Hedger*

Licensed Embalmer No. 2859

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11364  
Registrar's No. 33

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 417

Primary Registration District No. 3021

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

1. PLACE OF DEATH:  
(a) County Jasper  
(b) City or town Webb City  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Mary McDonald  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 64 Months 9 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name \_\_\_\_\_

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 \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar day 3  
year 1950 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute indigestion

Due to Gastroenteritis

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 120 lb

Major findings:  
Of operations \_\_\_\_\_  
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 P. B. Munson (M.D. or other) D. O.

Address Webb City \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

11364 (1940)