

APR 23 1940

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

12770

Do not use this space.

1. PLACE OF DEATH

(a) County Wayne Registration District No. 890
(b) Township St. Francois Primary Registration District No. 4539 Registered No. 9
(c) City Greenville or (d) Street No. 2 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

200 Kate S. McGee
(a) Residence, No. 0 St. 0 (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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>U.L. McGee McGee</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>March 2, 1867</u>		
7. AGE	YEARS <u>72</u>	MONTHS <u>11</u>
	DAYS <u>23</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housekeeper</u>	
	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) <u>Missouri</u> <u>0</u>		
FATHER	13. NAME <u>Sam Carlton</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u> <u>1</u>	
MOTHER	15. MAIDEN NAME <u>Nancy Weible</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u> <u>1</u>	
17. INFORMANT (ADDRESS) <u>Weible Carlton Greenville, Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>McGees Cemetery</u> DATE <u>Feb. 27, 1940.</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>F. C. Yates, Piedmont, Mo.</u>		
20. FILED <u>Mar 11, 1940</u> <u>Mabel Beasley</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 25, 1940

22. I HEREBY CERTIFY, That I attended deceased from July, 1985, to Feb 25, 1940
I last saw him alive on Feb 23, 1940 Death is said to have occurred on the date stated above, at 9 A m.
The principal cause of death and related causes of importance were as follows:

Cancer on back of neck
Date of onset 1930

Other contributory causes of importance: 570

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

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? no
If so, specify.....
(Signed) O. A. Mason M. D.
(Address) Greenville, Mo.

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

FORM 1 X 16605

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.

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.....

Ida M. Yates

Licensed Embalmer No. *2572*

P. O. Address *Piedmont 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12770

Registration District No. 896

Primary Registration District No. 4539

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Greenville
(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

Kate S. McGee

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 wid

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

Months

Days

If less than one day

72

11

23

hr. min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

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).....

(Burial, cremation, or removal)

(b) Date thereof.....

(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) Mar-11-40

(Date received local registrar)

(b) Mabel Beasley

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wayne
(c) City or town Greenville
(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 Feb day 25
year 1940 hour..... minute..... M.

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

Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:

Of operations.....

Of autopsy.....

Duration

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature O. A. Meyers (M. D. or other).....

Address Greenville Mo signed.....

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

SUPPLEMENTAL COPY

S-12770 1940