

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

14747

Do not use this space.

FILED MAY 15 1940

1. PLACE OF DEATH: (a) County Callao Registration District No. 243
 (b) Township Jackson Primary Registration District No. 5336
 (c) City Elkland Mo (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jacob McGee
 (a) Residence, No. Elkland Mo R 2 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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lou McGee

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 29-1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>66</u>	<u>8</u>	<u>25</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

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) mo (STATE OR COUNTRY) 0

FATHER: 13. NAME Martin McGee
 14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) 9

MOTHER: 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) 9

17. INFORMANT Lou McGee (ADDRESS) Elkland Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Chauty DATE 3-25-40

19. FUNERAL DIRECTOR (NAME) F. B. Jones (ADDRESS) Buffalo Mo.

20. FILED 4-5-40 1940 Mrs. G. H. Sheppard Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-24-40

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 11:30 a.m.

The principal cause of death and related causes of importance were as follows:
Heart attack
Arterial Sclerosis

Date of onset _____

Other contributory causes of importance: _____

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? _____
 If so, specify _____
 (Signed) Richard Coomer M. D.
 (Address) 220 Buffalo Mo

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.

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RECEIVED
District Health Officer No. 7,
District File Number 5-40-761
Date Filed 5-6-40

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.....
Licensed Embalmer No.....
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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. 14747

Registration District No. 243

Primary Registration District No. 5336

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Dallas
 (b) City or town JACKSON
(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 _____
years, months or days

3. (a) PRINT FULL NAME Jacob Mabee

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>8</u>	<u>25</u>	hours _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 3 day 24
 year 1940 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 Heart attack Duration

arterial sclerosis

Due to Coronary thrombosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 9412

Major findings: Of operations _____

Of autopsy _____

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 L. B. Jones Cor (M.D. or other)

Address Buffalo mo Date signed _____

SUPPLEMENTAL

S-14747