

NO. 2
1-10-39
17-39
X21492

State File No. _____

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 1074

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town "Rural" Washington Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. #3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 mo 20 days
(Specify whether _____)

In this community unknown
years, months or days

3. (a) PRINT FULL NAME James Thomas Daniels

3. (b) If veteran, name war unknown

3. (c) Social Security No. unknown

4. Sex M race W

5. Color or _____

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife If _____ years

7. Birth date of deceased 4 8 1867
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>11</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Labourer

11. Industry or business _____

MOTHER FATHER

12. Name William R Daniels

13. Birthplace Greene Co Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Malinda Young

15. Birthplace Greene Co Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Meranda Mo.

17. (a) Burial (b) Date thereof 4/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph Cemetery

18. (a) Signature of funeral director St. Joseph Funeral Soc.

(b) Address Meranda Mo.

19. (a) 4/1/40 (b) Allen V Hays
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Polk

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 1
year 1940 hour 3 minute 45A.M.

21. I hereby certify that I attended the deceased from 10-29, 1939, to 4-1, 1940,
that I last saw him alive on 3-31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Bronchopneumonia

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____
Of operations _____

Underline the cause to which death should be charged statistically.

Of autopsy Cerebr. & cardio sclerosis. Sacche
men. n. g. ity. Hemorrhagic infarct (cardiac)

22. If death was due to external causes, fill in the following: autifly

(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? 795
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address State Hosp. #3 Meranda Mo. signed 4/1/40

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

RECEIVED
District Health Officer No. 7,
District File Number 9-410-722
Date Filed 9-6-40

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 Allen V. Hays
Licensed Embalmer No. 1968
P. O. Address Nevada, 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.