

Registration District No. 1 JUN 7 1940 240 Primary Registration District No. 5408 State File No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Rural
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Jamie Paul McDaniel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race wh 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Albus McDaniel 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 17 - 1878
(Month) (Day) (Year)

8. AGE: Years 63 Months 4 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation housework

11. Industry or business _____
12. Name Link Gard
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name Jane Sandusky
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature Leslie Smith
(b) Address Smith, Mo.

17. (a) Burial (b) Date thereof 6-2-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation McDaniel

18. (a) Signature of funeral director McDaniel
(b) Address Smith, Mo.

19. (a) June 7 (b) William Daniel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dunklin
(c) City or town Rural
(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 6 day 1
year 1940 hour 5 minute 40 a. m.

21. I hereby certify that I attended the deceased from April
1940, 1940 to June 1, 1940
that I last saw her alive on May 31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage Duration 8 wks.

Due to Hypertension about 7/2

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? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Ray E. Brand (M. D. or other) mo
Address Smith, Mo. Date signed 6-1-40

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should 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.

District File Number 640-112

Date Filed 6/11/40

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.....

H. P. Gooch

Registered Apprentice No.....

working under my personal supervision.

Signed.....

H. P. Gooch

Licensed Embalmer No. 4106

P. O. Address Senath 770

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.