

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 149

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

**1. PLACE OF DEATH:**  
 (a) County Yernon  
 (b) City or town Rural Washington  
(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 1/2 mo 27 da  
(Specify whether years, months or days)  
 In this community unknown

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Bayton  
 (c) City or town County Farm  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 0  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** Thomas McDaniel 232  
 3. (b) If veteran, name war unknown 3. (c) Social Security No. unknown

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month June day 2 year 1940 hour 6 40 minute P.M.

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife unknown (c) Age of husband or wife if alive unknown years

21. I hereby certify that I attended the deceased from 1-25, 1939, to 6-2, 1940  
 that I last saw him alive on 6-2, 1940  
 and that death occurred on the date and hour stated above.

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

Immediate cause of death Chronic Myocarditis with Hypertension

8. AGE: Years about 81 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to 97c

9. Birthplace unknown Iowa  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer  
 11. Industry or business \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

**MOTHER FATHER**  
 12. Name Wm McDaniel  
 13. Birthplace Lee County Iowa  
(City, town, or county) (State or foreign country)  
 14. Maiden name Sarah Cook  
 15. Birthplace Penn.  
(City, town, or county) (State or foreign country)  
 16. (a) Informant Hosp #3 Record  
 (b) Address Nevada mo  
 17. (a) Burial (b) Date thereof 6/6/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation  Hosp. -  
 18. (a) Signature of funeral director Wm. C. Biehinger  
 (b) Address Nevada mo.  
 19. (a) 6-5-40 (b) Allen V. ...  
(Date received local registrar) (Registrar's signature)

**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) (If means of injury)  
 23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address State Hosp #3 Nevada Date signed 6-2-40

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

RECEIVED

District Healer Officer No. 7,

District File Number 7-40-1031

Date Filed 7-9-40

**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 Marsh Eichinger

Licensed Embalmer No. 26676

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.**