

Registration District No. MO 20 4040

Primary Registration District No. 6190

Registrar's No.

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Medee
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
John Wm. McDaniel 2
(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 _____ (Specify whether _____)

3. (a) PRINT FULL NAME John Wm McDaniel

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced man

6. (b) Name of husband or wife Emily McDaniel 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased May 23 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name John McDaniel
13. Birthplace Unknown
14. Maiden name Susan Fyfe
15. Birthplace Kenn.

16. (a) Informant W.C. McDaniel, son
(b) Address Kennett, Mo. R2

17. (a) _____ (b) Date thereof June 20-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Hope, Medee, Mo

18. (a) Signature of funeral director W. H. ...
(b) Address Deering, Mo

19. (a) July 2-40 (b) S. M. ...
(If to receive local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wayne
(c) City or town Medee
(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 June day 20 year 1940 hour 11 am minute _____ M.

21. I hereby certify that I attended the deceased from May 1, 1940, to June 20, 1940 that I last saw him alive on about May 1, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Throat Duration _____

Due to carcinoma of esophagus
remained for 2 years
Due to while in hospital

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations
Of autopsy ✓
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? 812
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Ch. ... (M. D. or other) ✓
Address Quincy, Mo Date signed _____

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

57

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 comply 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. 23094

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1020

Primary Registration District No. 6190

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Jefferson T. P.
(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 Jos Wm McDaniel

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 mar

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 76 Months _____ Days 27 If less than one day _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(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.

20. DATE OF DEATH: Month June day 20 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 Carcinoma of throat

Duration Carcinoma? can removed 1 or 2 yrs
Due to age

Other conditions started on ear
(Include pregnancy within 3 months of death)
on was removed

Major findings: metastatic tumor
Of operations in upper jaw and throat
Of autopsy by Dr

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 E. J. Elmore (M. D. or other)
Address Physician Date signed _____

SUPPLEMENTARY

