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13-40
7-39
K23159

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 716

1. PLACE OF DEATH:
(a) County BUCHANAN 3
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution State Hspital # 2
In this community 2 mos. 14 ds.
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Joseph Walker Mc Tary 210
3. (b) If veteran name war — 3. (c) Social Security No. —

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced wid.
6. (b) Name of husband or wife Minnie B. 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Aug. 19, 1877
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days 15 If less than one day hr. min.

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

10. Usual occupation ?

11. Industry or business ?

MOTHER, FATHER { 12. Name Wm. Mc Tary
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Howe
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Mc Tary
(b) Address Lafleta Mo.

17. (a) Removed (b) Date thereof 7-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lafleta Mo.

18. (a) Signature of funeral director D. S. Christee
(b) Address Lafleta Mo.

19. (a) 7/5/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 4
year 1940 hour 8 minute 35 A. M.

21. I hereby certify that I attended the deceased from 4/23/40
—, 19— to 7/4/40, 1940
that I last saw him alive on 7/4/40
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia 5 ds.
Duration

Due to 10 ds
Due to ?

Other conditions arteriosclerosis
(Include pregnancy within 3 months of death) with hypertension

Major findings: Of operations none Of autopsy none
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) 85
(b) Date of occurrence 7/4/40
(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 [Signature] (M. D. or other) ?
Address Lafleta Mo. Date signed 7/4/40

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

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.