DEPARTMENT OF COMMERCE
23 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25020

Registration District No. 234 Primary Registration District No. 5 32 Registrar's No.

29

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should s CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import

1. PLACE OF DEATH:

(a) County: Dade Ernest Twsp.

(b) City or town: Greenfield, Mo. Rt. 2 (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community: Many years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Dade

(c) City or town: Greenfield, Mo. Rt. 2 (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.

3. (a) PRINT FULL NAME: Bertha Mable McMahan. 255

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: Husband Wm. McMahan

6. (c) Age of husband or wife if alive: 68 years

7. Birth date of deceased: Aug. 1, 1940. (Month) (Day) (Year)

8. AGE: Years 63 | Months 4 | Days 29 | If less than one day hr. min.

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

10. Usual occupation: House keeping

11. Industry or business:

FATHER 12. Name: G.F.Nall

13. Birthplace: Kentuckey (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Amanda Wright

15. Birthplace: Hardin Co. Ky. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: W. A. Mc Mahan

(b) Address: Greenfield, Mo. Rt. 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 2. 40. (Month) (Day) (Year)

(c) Place: burial or cremation: Pleasent Grove Cem.

18. (a) Signature of funeral director: J. W. Ward

(b) Address: Greenfield Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1 year 1940 hour 5 minute 15 A.M.

21. I hereby certify that I attended the deceased from 7-24-40, 19, to Aug 1, 19 40, that I last saw he alive on 7-31-, 19 40; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage

Due to:

Due to:

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

Major findings: Of operations:

Of autopsy:

Duration

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: A O Cowan (M. D. or other)

Address: Greenfield Mo Date signed 8-7-40

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 Form 1 X19511

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 J. W. Ward

Licensed Embalmer No. 2832

P. O. Address Greenfield, 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.

. S. No. 2B
M—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20-020

Registration District No. 238 Primary Registration District No. 5325 Registrar's No.

1. PLACE OF DEATH:
(a) County: Dade
(b) City or town: Ernest 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 years, months or days)
In this community

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.

3. (a) PERSONAL NAME OF DECEASED: Bertha Mebel McMahan
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: m
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 63 Months 4 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 8-31-1940 (Date received local registrar) (b) J. A. Wren (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1 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 — *Duration*
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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: N. O. Cowgill (M. D. or other)
Address: Greenfield Mo. Date signed

SUPPLEMENTARY