

Da. Davis

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25774**
Registrar's No. **95**

FILED AUG 3 1940

Registration District No. **3-66**

Primary Registration District No. **5762**

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Burns
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Charleston Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community 5 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Unknown
(c) City or town Kansas City
(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 NEAL Mc DONALD 235

3. (b) If veteran, name war ✓ 3. (c) Social Security No. None

4. Sex M 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 16, 1892
(Month) (Day) (Year)

8. AGE: Years 48 Months 0 Days 0 If less than one day hr. _____ min.

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

10. Usual occupation Day laborer

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ernest Jarwood

(b) Address Charleston Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17, 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

18. (a) Signature of funeral director Praxis Shelby

(b) Address East Praxis Mo

19. (a) 7-16-40 (Date received local registrar) (b) J. Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1940 hour 6.30 minute _____ a. M.

21. I hereby certify that I attended the deceased from July 6, 1940 to July 16, 1940 that I last saw him alive on July 6, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis Duration 3 weeks

Due to _____

Due to _____

Other conditions Epilepsy
(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? 375

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature William J. Davis (M. D. or other) M.D.

Address Charleston Mo Date signed 7-16-40

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

85

RECEIVED

District Health Officer No. 2,

District File Number 840-127

Date Filed 8/2/40

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 Travis Shelby

Licensed Embalmer No. 2756

P. O. Address East Prairie, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

File No. **23-774**
Registrar's No. **95-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **566**

Primary Registration District No. **5762**

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

1. PLACE OF DEATH:

(a) County **Mississippi**
(b) City **Spartanburg, 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 **Neal Mc Donald**

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

4. Sex **m** 5. Color **col** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE: Years Months Days If less than one day _____ hr _____ 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)

(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 **July** day **16** 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 _____ and that death occurred on the date and hour stated above. Immediate cause of death **Thrombosis**

Due to **Chronic nephritis** Duration **6 months**

Due to _____ Duration **6 months**

Other conditions **Epilepsy** (Include pregnancy within 3 months of death) **131**

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

