

FD-203
 Rev. 5-17-39
 X21492

21 1940

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

26020

State File No. _____

Registration District No. 688

Primary Registration District No. 5916

Registrar's No. 15

82

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

1. PLACE OF DEATH:
 (a) County Pike
 (b) City or town Frankford
 (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 Life (Specify whether
 In this community Life years, months or days)

3. (a) PRINT FULL NAME Leila Isabelle McQuay

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

4. Sex Female 5. Color Black 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased May 28 1940
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 1 7 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Carl McQuay

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

14. Maiden name Alva Miller

15. Birthplace New London Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Carl McQuay
 (b) Address Frankford Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6 1940
 (Month) (Day) (Year)

(c) Place: burial or cremation Frankford Missouri

18. (a) Signature of funeral director Fields & Son
 (b) Address Frankford Missouri

19. (a) July 20 (Date received local registrar) (b) Mattie Ursell (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pike
 (c) City or town Frankford
 (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 5
 year 1940 hour 13 minute 0

21. I hereby certify that I attended the deceased from June 26
1940 to July 5, 1940
 that I last saw him alive on July 5 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial infarction 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 OWE SUNDGREN (M. D. or other) _____

Address Frankford Mo Date signed 6/6/40

REMOVED

District Health Officer No. 10

District File Number 8-40-1559

Date Filed AUG 8 1940

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 Lois Fields Mequon

Licensed Embalmer No. 4093

P. O. Address Frankford, 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.