

Registration District No. **408**

Primary Registration District No. **3020**

Registrar's No. **161**

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Carthage**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Stone Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
In this community **25 Years, 6 Mo., 13 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Bina Mae McCandless**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**

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

7. Birth date of deceased **Jan 30, 1915**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	25	6	13	hr. _____ min. _____

9. Birthplace **Stotts City, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Joseph Robertson**
13. Birthplace **unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Nattie Davis**
15. Birthplace **Stotts City, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Everett McCandless**
(b) Address **Route # 1, Stotts City, Mo.**

17. (a) **Burial** (b) Date thereof **8-15-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sarcoxie, Cemetery,**

18. (a) Signature of funeral director **Ed. C. Ulmer**
(b) Address **1208 Garrison, Carthage, Mo.**

19. (a) **Aug. 15, 1940** (b) **E. J. McIntire, M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence**
(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")
(d) Street No. **Stotts City, Mo. Route #1.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **13**
year **1940** hour **6:18** minute **26** P.M.

21. I hereby certify that I attended the deceased from **Aug 12**, 1940, to **Aug 13**, 1940:
that I last saw her alive on **Aug 13**, 1940:
and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxiation following operation of appendix**
Due to _____

Due to _____

Other conditions **Surgical shock**
(Include pregnancy within 3 months of death)

Major findings: Of operations **Chronic appendix and**
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? **865**

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

23. Signature **D. M. A. Davis** (M. D. or other) **D.O.**
Address **323 Main, Carthage** Date signed **Aug 15, 1940**

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

