

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.

Registration District No. 449

Primary Registration District No. 4267

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town LEBANON  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 10 DAYS (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME TOM McNAMARA 255

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased (Month) Mar (Day) 22 (Year) 1917

8. AGE: Years 15 Months 4 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Schoolboy

11. Industry or business \_\_\_\_\_

12. Name CHRIS McNAMARA

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

14. Maiden name BRIDGE McNAMARA

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

16. (a) Informant's own signature Mr Palmer

(b) Address \_\_\_\_\_

17. (a) REMOVAL (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation MEMPHIS TENN

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON Mo.

19. (a) 8-5-40 (b) J. A. McComb (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State TENN (b) County \_\_\_\_\_

(c) City or town MEMPHIS  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 4  
year 1940 hour 8 minute 1 A.M.

21. I hereby certify that I attended the deceased from 8-1 to 8-4, 1940,  
that I last saw him alive on 8-4 and that death occurred on the date and hour stated above.

Immediate cause of death Sepsisemia

Due to Purpura of gambis

Due to Pertussis 10 days

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Quercus - 121

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? 444 (Specify type of place)

While at work? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature Walter Wallace (M. D. \_\_\_\_\_)

Address Lebanon Date signed 8-5-40

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

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1302

Date Filed 9-16-40

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

*R. D. Babner*

Licensed Embalmer No. 1161

P. O. Address Stanton 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.