

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33286**

Registration District No. **827**

Primary Registration District No. **4500**

Registrar's No. **23**

1. PLACE OF DEATH:

(a) County **Shelby**  
(b) City or town **Clarence**  
(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 **2**  
In this community **all her life** (Specify whether years, months or days)

8. (a) PRINT FULL NAME **ora. M. Daniel**

8. (b) If veteran, name war **-** 8. (c) Social Security No. **None**

4. **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**  
6. (b) Name of husband or wife **-** 6. (c) Age of husband or wife if alive **-** years

7. Birth date of deceased **Jan 18-1884**  
(Month) (Day) (Year)

8. AGE: Years **26** Months **7** Days **13** If less than one day hr. min.

9. Birthplace **Mo. 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Nurse**

11. Industry or business **-**

12. Name **John S. Daniel**

13. Birthplace **R. Y.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Huber**

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

16. (a) Informant **J. Daniel**

(b) Address **Clarence Mo**

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

(c) Place: burial or cremation **Clarence Mo**

18. (a) Signature of funeral director **H. Hopper**

(b) Address **Clarence Mo**

19. (a) **Sept 12 1940** (b) **Key Hamilton**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Shelby**  
(c) City or town **Clarence, Mo.**  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **28**  
year **1940** hour **4 a.m.** minute **-** M.

21. I hereby certify that I attended the deceased from **July 1936**, 19 **-**, to **August 28**, 19 **-**, that I last saw her alive on **Aug 27 1940**, 19 **-**, and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Bronchitis** Duration **4 da**

Due to **Pulmonary tuberculosis** **20 yrs**

Due to **Renal tuberculosis** **2 yrs**

**Nephrectomy about 1920**  
Other conditions **bronchectiasis**  
(Include pregnancy within 3 months of death)

Major findings: **Renal tuberculosis**  
Of operations **1920**

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) **NO**

(b) Date of occurrence **NO**

(c) Where did injury occur? **NO**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **NO**

**5** While at work? **NO** (Specify type of place)  
(i) Means of injury **1 mo**

23. Signature **D. L. Harlan** Date signed **Sept 9-10-40**  
Address **Clarence, Mo.**

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

22  
0

RECEIVED

District Health Officer No. 10

District File Number 10-40-1878

Date Filed OCT 9 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 Jack Hayes

Licensed Embalmer No. 3699

P. O. Address Shelbina, 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.