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NOV 19 1940

Registration District No. 1

Primary Registration District No. 1

Registrar's No. 246

1. PLACE OF DEATH:

(a) County Adair
(b) City or town near Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trimm-Smith Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 hour
(Specify whether
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Roy E. Mc Bee

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

4. Sex Male 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 September 15 1923
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
17 1 8 hr. _____ min.

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

10. Usual occupation Farming 0

11. Industry or business 0

MOTHER FATHER { 12. Name Samuel F. Mc Bee

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

14. Maiden name Neva Collins

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

16. (a) Informant Edgar C. Casper

(b) Address Queen City Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Jugate Cemetery

18. (a) Signature of funeral director Wm. M. West
(b) Address Queen City Mo.

19. (a) Oct. 24, 40 (Date received local Registrar) (b) Spencer L. Treason (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Schuyler
(c) City or town Queen City
(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 Oct. day 23rd
year 1940 hour about 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from since on my annual 19 _____ to _____ 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death fracture of skull & broken neck

Due to auto & motorcycle accident head on collision

Due to _____

Other conditions (Include pregnancy within 3 months of death) 2 1/2 m 7 1/2

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 10-23-40

(c) Where did injury occur? 4 miles S of Stanton Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
3 on highway 63

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

23. Signature C. D. Davis M.D. coroner (M. D. or other)
Address _____ Date signed _____

Duration
Physician
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 11-40-2145

Date Filed NOV 14 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 Myself

Registered Apprentice No. _____

working under my personal supervision.

Signed Wm. J. West

Licensed Embalmer No. 2882

P. O. Address Queens City

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.