Dupl. of 36186-40

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

NOV 21 1940

State File No. 36175

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County: Ray
(b) City or town: Cowgill, #2
(If outside city or town limits, write "RURAL" and name of township)
(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 (Specify whether years, months or days)
In this community: 0

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Ray
(c) City or town: Cowgill Rural
(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.

3. (a) PRINT FULL NAME: Helen Dorcas McCam
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: —
4. Sex: Fe
5. Color or race: W
6. (a) Single, widowed, married, divorced: Wid
6. (b) Name of husband or wife: Willis T. McCam
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: Aug (Month) 8 (Day) 1856 (Year)

8. AGE: Years 84 Months 2 Days 28 If less than one day _____ hr. _____ min.

9. Birthplace: Unknown (City, town, or county) Ky (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: —
FATHER
12. Name: Thomas McCamp
13. Birthplace: Ky (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Mary Ann Mullikin
15. Birthplace: — (City, town, or county) Ky (State or foreign country)
16. (a) Informant: William Owen
(b) Address: Cowgill, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-9-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Antioch
18. (a) Signature of funeral director: B. D. Mead
(b) Address: Bragger, Mo
19. (a) _____ (Date received local registrar) Mrs Irene Mansur (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6th year 1940 hour 11:00 minute 30 A.M. P.M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Apoplexy 3 hr
Due to: Rheum
Due to: _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Duration

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: _____ (M. D. or other)
Address: _____ Date signed: _____

669 (Licensed Embalmer's Statement on Reverse Side)

2 D B

117
23
142

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-14-40

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 Bernard L. Mead

Licensed Embalmer No. 2801

P. O. Address Braymer

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36175

Registration District No. 34 914 Primary Registration District No. 6235

Registrar's No.

1. PLACE OF DEATH:

(a) County: Ray

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

(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 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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.

3. (a) PRINT FULL NAME: Helen Doreas McCan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: wd

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 84 Months 2 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Mrs Isaiah Mannon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY