

Registration District No. 408

Primary Registration District No. 5562

Registrar's No. 202

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carroll - Marion Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 7 years _____ years, months or days) (Specify whether
2

3. (a) PRINT FULL NAME MINA S. Mc DANIEL

3. (b) If veteran, name war No 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 Carl M. Daniel 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 21 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name William Seagraves
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Johnson
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Carl M. Daniel

(b) Address Route 4 - Carthage, Mo.

17. (a) Carroll (b) Date thereof Nov. 5 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fullerton Cemetery

18. (a) Signature of funeral director Knee M. Ostrow

(b) Address Carthage, Mo.

19. (a) Nov. 6, 1940 (b) E. J. Mc Intire, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Carthage
(If outside city or town limits, write "RURAL")
(d) Street No. Route 4
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4
year 1940 hour 9 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw her or died November 5 - 1940
alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____

Due to _____
Due to _____ \$20

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy View

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

23. Signature L. W. Winkler, Coroner (M. D. or other)
Address Jasper, Mo. Date signed 11-5-40

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

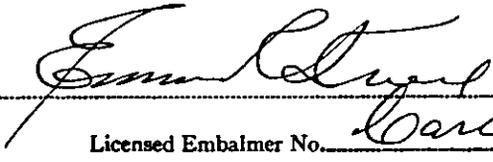
9

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


.....
Licensed Embalmer No. Barbey

P. O. Address 391

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.