

DEC 11 1940 238

Registration District No. \_\_\_\_\_

Primary Registration District No. 6098B

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Dexter, Mo. R. F. D.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
None  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town Dexter, Mo. R. F. D.  
(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 MALINDA E. McDANIEL

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased Jan. 22, 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>10</u>	<u>6</u>	hr. _____ min.

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

10. Usual occupation Housewife

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

12. Name B. G. Manguen

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

14. Maiden name Unknown

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

16. (a) Informant W. H. McDaniel

(b) Address 4410 Washington ave. St. Louis, Mo.

17. (a) Burial (b) Date thereof 11-29-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walker cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) 12/3 1940 Jennie Burton (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27  
year 1940 hour 10 minute 35 P.M.

21. I hereby certify that I attended the deceased from 1-12-1940 to 11-27-1940  
that I last saw him alive on 11-19-1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive pneumonia

Due to Hypertension, cerebral hemorrhage with hemiplegia

Due to arterio sclerosis

Other conditions Chronic G. B.  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations none

Of autopsy none

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? 755

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

23. Signature Frank Haber (M. D. or other) M.D.  
Address Dexter Date signed 12/2/40

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

MOTHER FATHER

RECEIVED

District Health Officer No. 2,

District File Number 1240-170

Date Filed 12/9/40

**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.....

Licensed Embalmer No.....

DECEASED WAS NOT EMBALMED \*\*\*\*\*

P. O. Address.....

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, fact should be so stated above.