

No. 2
-13-40
-17-39
X23150

Registration District No. **147**

Primary Registration District No. **5698**

Registrar's No. _____

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

1. PLACE OF DEATH: **McDonald**
 (a) County **McDonald**
 (b) City or town **Rural Buffalo Gap**
 (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 _____)
 In this community _____ years, months or days _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **McDonald**
 (c) City or town **Goodman**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **R.F. No. 1**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? **0** years

3. (a) PRINT FULL NAME **Charles L. Guzman Divine**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Dec** day **24** year **1940** hour **11** minute **30** P.M.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **1**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Dec 20 - 1940**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Dec 20**, 19**40** to **Dec 24**, 19**40** that I last saw him alive on **Dec 20**, 19**40** and that death occurred on the date and hour stated above.

8. AGE: Years **0** Months **0** Days **4** If less than one day hr. _____ min. _____

Immediate cause of death **Pneumonia**
 Due to **7 months**
 Due to **15A**
 Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 10. Usual occupation _____

Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business _____
 12. Name **Leroy Divine**
 13. Birthplace **Mo** (City, town, or county) _____ (State or foreign country)
 14. Maiden name **Violet Galt**
 15. Birthplace **Okla** (City, town, or county) _____ (State or foreign country)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **no**
 (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? **41st**
 _____ (Specify type of place) _____ (e) Means of injury _____
 23. Signature **W. B. Thresh** (M. D. or other) **D**
 Address **Anderson Mo** Date signed **Dec 26**

16. (a) Informant **Leroy Divine**
 (b) Address **Goodman Mo**
 17. (a) **Burial** (b) Date thereof **Dec 25 - 40**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Stephenson Mo**
 18. (a) Signature of funeral director **Charles Williams**
 (b) Address **Goodman Mo**
 19. (a) **2 - 10 - 41** (b) **Charles Williams**
 (Date received local registrar) (Registrar's signature)

RECEIVED

District No. 1000 No. 01

District File No. 241-343

Date Filed OCT 17 1941

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.....

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.