

Registration District No. 900Primary Registration District No. 6208

1. PLACE OF DEATH:

(a) County Webster
 (b) City or town Rural-Union township
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
x /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution x
 (Specify whether
 In this community 55 years
 years, months or days)

8. (a) PRINT FULL NAME David George8. (b) If veteran, name war Civil8. (c) Social Security No. x4. Sex Male 5. Color or race x 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Wula George 6. (c) Age of husband or wife if alive x years7. Birth date of deceased October 28 - 1850
(Month) (Day) (Year)8. AGE: Years 90 Months 3 Days 21 If less than one day x hr. x min.9. Birthplace Ray County, Tennessee
(City, town, or county) (State or foreign country)10. Usual occupation Stockman11. Industry or business Farm12. Name Jacob George18. Birthplace Tennessee
(City, town, or county) (State or foreign country)14. Maiden name Sally Ann Ryan15. Birthplace Tennessee
(City, town, or county) (State or foreign country)18. (a) Informant's own signature Mrs. J. O. Bailey
(b) Address Cairo, Illinois17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-41
(Month) (Day) (Year)(c) Place: burial or cremation Prospect18. (a) Signature of funeral director Tex Rainey(b) Address Marshfield, Missouri19. (a) Nov 7 - 41 (Date received local registrar) (b) Hullie Schlicht (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster
 (c) City or town Rural-Union township
 (If outside city or town limits, write "RURAL")
 (d) Street No. x (If rural, give location) 0
 (e) If foreign born, how long in U. S. A. x years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19
year 1941 hour 7 minute 30 A. M.21. I hereby certify that I attended the deceased from Feb 1,
1941, to Feb. 19, 1941;
that I last saw him alive on February 18, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death.

Paralysis - Rt. Hemiplegia Duration 3 daysDue to Cerebral Hemorrhage 3 daysDue to Arteriosclerosis - general 10 yrsOther conditions
(Include pregnancy within 3 months of death) (3 W)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?
9 11 11

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

23. Signature CP Macdonnell (M. D. or other) M.D.
Address Marshfield, Mo Date signed 2/20/40

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

Tex Loney

Licensed Embalmer No.

3312

P. O. Address

Marshfield, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 85257

Registration District No. 900

Primary Registration District No. 6208

Registrar's No. 6208

1. PLACE OF DEATH:

(a) County Webster
(b) City or town Union Twp
(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

3. (a) PRINT FULL NAME David George

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race white 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

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

8. AGE: Years Months Days If less than one day
90 3 21 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (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) Hallie Schledt (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 13
year _____ hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 C. R. McQuaid (M. D. or other)

Address Marshall Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

