

1-4-41  
17-39  
X26390

DEPARTMENT OF COMMERCE  
FILLED SEP 24 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29145

Registration District No. 125

Primary Registration District No. 4431

Registrar's No.

1. PLACE OF DEATH:

(a) County Ralls  
(b) City or town Rural Co  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Ralls County Infirmary  
(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 Missouri (b) County Ralls  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2  
year 1941 hour 8:30 P.M. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from July 1  
1941 to Aug 27 1941  
that I last saw her alive on July 31, 1941 1941  
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Emma McCann

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

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

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

7. Birth date of deceased Oct. 12 1865  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>11</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation \_\_\_\_\_

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

12. Name Benjamin McCann

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

14. Maiden name Polly Frazer

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

16. (a) Informant Lillian O'Keefe

(b) Address Ralls County

17. (a) Burial (b) Date thereof 8 5 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salt Lick Cemetery

18. (a) Signature of funeral director James O'Sullivan

(b) Address Hannibal Mo.

19. (a) Angela (b) James O'Sullivan  
(Date received local registrar) (Registrar's signature)

Immediate cause of death Myocardial death  
Due to unknown  
Due to \_\_\_\_\_  
Other conditions unknown  
(Include pregnancy within 3 months of death)

Duration  
5 days

PHYSICIAN  
Major findings:  
Of operations 930  
Of autopsy \_\_\_\_\_  
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 J. H. Proctor (M. D. or other) MD  
Address Center Mo Date signed Aug 1941

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

81  
00

RECEIVED

District Health Officer No. 10

District File Number 9-41-1710

Date Filed SEP 18 1949

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.....

*Harold O'Rourke*

Licensed Embalmer No. 3889

P. O. Address Hamlet, N.C.

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.