

**FILED SEP 17 1945**  
**STANDARD CERTIFICATE OF DEATH**

State File No. 29198a

Registration District No. 1 Primary Registration District No. 1 Registrar's No. 0

**1. PLACE OF DEATH:**  
(a) County Ray County Mo.  
(b) City or town Waynesville  
(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) (Specify whether  
years, months or days)

**3. (a) PRINT FULL NAME:** Marilyn Gladney McElure  
**3. (b) If veteran,** name war \_\_\_\_\_ **(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:** July 30 1941  
(Month) (Day) (Year)

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace:** Ray County Mo.  
(City, town, or county) (State or foreign country)

**10. Usual occupation:** \_\_\_\_\_

**11. Industry or business:** \_\_\_\_\_  
**12. Name:** Henry McElure  
**13. Birthplace:** Ray County Mo.  
(City, town, or county) (State or foreign country)  
**14. Maiden name:** Maudie Schmitt  
**15. Birthplace:** Howard Co. Mo.  
(City, town, or county) (State or foreign country)

**16. (a) Informant's own signature:** H. McElure  
**(b) Address:** Polo Mo.

**17. (a) Burial:** \_\_\_\_\_ **(b) Date thereof:** July 31 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation:** Bethel Cemetery

**18. (a) Signature of funeral director:** C. L. Reed  
**(b) Address:** Cougill Mo.

**19. (a) \_\_\_\_\_ (b) \_\_\_\_\_**  
(Date received local registrar) (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) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month July day 30  
year 1941 hour 15 minute 30 AM  
**21. I hereby certify that I attended the deceased from** July 30, 1941, to July 30, 1941;  
that I last saw her alive on July 30, 1941  
and that death occurred on the date and hour stated above.

**Immediate cause of death:** 8 months premature  
**Due to:** Insufficiency of foramen ovale below  
**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? \_\_\_\_\_

**23. Signature:** G. W. Gaines M.D. (M. D. or other) \_\_\_\_\_  
**Address:** Richmond, Mo. **Date signed:** July 31 1941

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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..... *C. Reed* .....  
Licensed Embalmer No. *2194* .....  
P. O. Address *Council Bluffs* .....

**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. 29198

Registration District No. 915

Primary Registration District No. 6236

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

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Knobsville 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 1941 year. 30 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I first saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Marilyn S. McElwaine

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased July 30 1941  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ 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 \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Oct 20 1941 (b) Neonie Kelly  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

SUPPLEMENTARY

