

Registration District No. **806** Primary Registration District No. **4485** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: **Schuyler**  
 (a) County **Schuyler**  
 (b) City or town **Green Lake, Mo**  
 (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 **76 years** years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Schuyler**  
 (c) City or town **Green Lake**  
 (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.? **0** years.

3. (a) PRINT FULL NAME **Lurilla McNaught**  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **8** day **17** year **41** hour **12** minute **50 A.M.**

4. Sex **Female** 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife **J. W. McNaught**  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Dec 5 1856**  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **8-6-41**, 19\_\_\_\_, to **Time of death**, 19**41** that I last saw her alive on **8-16**, 19**41** and that death occurred on the date and hour stated above.

8. AGE: Years **84** Months **8** Days **9** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death **Cerebral Anoxia** Duration \_\_\_\_\_

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

Due to \_\_\_\_\_  
 Due to **43A**  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name **Bolton Fisher**  
 13. Birthplace **Ohio** (City, town, or county) (State or foreign country)  
 14. Maiden name **Elizabeth Morgan**  
 15. Birthplace **Ohio** (City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Mary E. McDowell**  
 (b) Address **Queen City Mo**  
 17. (a) \_\_\_\_\_ (b) Date thereof **8-18-41**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Green Lake, Mo**  
 18. (a) Signature of funeral director **B. C. Dyer**  
 (b) Address \_\_\_\_\_  
 19. (a) **8-18-41** (b) **Olive B Jones**  
 (Date received local registrar) (Signature of Registrar)

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? \_\_\_\_\_  
 (Specify type of place) (e) Means of injury \_\_\_\_\_  
 While at work? \_\_\_\_\_  
 23. Signature **Dr. C. H. W. ...** (or other)  
 Address **Green Top Mo** Date signed **8-17-41**

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

78  
00

RECEIVED

District Health Officer No. 10

District File Number *84-1639*

Date Filed *SEP 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.....

working under my personal supervision.

....., Registered Apprentice No.

*not embalmed*

Signed.....

*E. E. [Signature]*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29516

Registration District No. 8062 Primary Registration District No. 4485 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Schuyler  
(b) City or town \_\_\_\_\_  
(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 Luella McNaught  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 5. Color or race M. 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 8 1885  
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days \_\_\_\_\_ (If less than one day) \_\_\_\_\_ min.

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

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

11. Industry of 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 Clarence, 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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year 41 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last 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)

(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

Green City, Mo

