DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 11 1941

Registration District No. 318

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34981

Primary Registration District No. 5440

Registrar's No. 850

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town ~~Springfield~~ Rural S Campbell
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Ozark Osteopathic Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 da. (Specify whether years, months or days)

In this community 3 da.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Webster

(c) City or town Rogersville (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. 112
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME Charles Wilburn McDonald

3. (b) If veteran, name war NO

3. (c) Social Security No. 500-01-6270

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Birdie Annabelle McDonald

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased Feb. (Month) 12 (Day), 1884 (Year)

8. AGE: Years 57 Months 8 Days 10 If less than one day ____ hr. ____ min.

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

10. Usual occupation Farmer

11. Industry or business —

FATHER
12. Name Francis Marion McDonald
13. Birthplace Webster Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Adelina Morris
15. Birthplace Webster Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Birdie Annabelle McDonald
(b) Address Rogersville, Mo. R.R. #3

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof 10-25-41 (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Grove

18. (a) Signature of funeral director Ray Lainey
(b) Address Marshfield Mo.

19. (a) 10-28-41 (Date received by local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 23 year 1941 hour 12 minute 10 A.M.

21. I hereby certify that I attended the deceased from Oct. 18, 1941, to Oct. 23, 1941, that I last saw him alive on Oct. 22, 1941, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Peritonitis	
Due to: Perforated peptic ulcer	
Due to: 2	
Other conditions (Include pregnancy within 3 months of death): 1170	

Major findings:
Of operations: Perforated peptic ulcer
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. E. Blair (M. D. or other) D.O.
Address 2108 S. Holland Date signed 10/23/41

W.E.H. (Licensed Embalmer's Statement on Reverse Side)

8—140
1

SEP 9 1952

OCT 6 1952

DEC 12 1944

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 Lix Lainey

Licensed Embalmer No. 3312

P. O. Address Marshfield M

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.

V. S. No. 2B
10M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34981

Registration District No. 318 Primary Registration District No. 5440 Registrar's No. 850

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Rural
(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 years, months or days)
In this community .....

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. (a) PRINT FULL NAME: Charles W. McDonald
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Feb (Month) 12 (Day) 1884 (Year)

8. AGE: Years 57 Months 8 Days XX If less than one day hr. ..... min.

9. Birthplace: Mo (City, town, or county) (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
MOTHER FATHER
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) Burial (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) 12-5-41 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23 year 1941 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h. alive on ..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

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

SUPPLEMENTARY