

Dr. *W. H. B. B. B.* 48201  
State File No. *48201*

Registration District No. *874* Primary Registration District No. *6151B* Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County *Vernon*  
(b) City or town *Rural*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution  
*Moundville, Mo. 10*  
(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 *Mo* (b) County *Vernon*  
(c) City or town *Moundville* (If outside city or town limits, write "RURAL")  
(d) Street No. *S. of Moundville, Mo.* (If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME *Ray J. McDonald*  
(b) If veteran, name war *no* (c) Social Security No. *no*

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month *Jan* day *15<sup>th</sup>* year *1942* hour *9:00 AM* minute \_\_\_\_\_ M.

4. Sex *Male* 5. Color or race *White* 6. (a) Single, widowed, married, divorced *Married*  
7. Birth date of deceased *Mar 4 1881* (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Jan 15<sup>th</sup> 1942* to *Jan 18<sup>th</sup> 1942* and that I last saw him alive on *Jan 18<sup>th</sup> 1942* and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<i>60</i>	<i>10</i>	<i>11</i>	hr. _____ min. _____

Immediate cause of death *Internal Hemorrhage*

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

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation *Farming*

11. Industry or business \_\_\_\_\_  
12. Name *A. J. McDonald*  
13. Birthplace *Vernon Canada* (City, town, or county) (State or foreign country)  
14. Maiden name *Sarah Osborough*  
15. Birthplace *Mercer Co. Ill* (City, town, or county) (State or foreign country)

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

16. (a) Informant *Mrs. Gertrude McDonald*  
(b) Address *Moundville, Mo*  
17. (a) *Burial* (b) Date thereof *1/18/42* (Month) (Day) (Year)  
(c) Place: burial or cremation *Willham Cem*  
18. (a) Signature of funeral director *Ward Cochran*  
(b) Address *Nevada, Mo*  
19. (a) *Jan 13 1942* (Date received local registrar) (b) *Mrs. N. O. Primm* (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence *Jan 15 1942*  
(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 *W. H. B. B.* (M. D. or other) Address *Moundville, Mo.* Date signed *1-18-42*

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

2  
39  
8008

**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 Mark E. Schenker

Licensed Embalmer No. 9656

P. O. Address Nevada 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. 43201

Registration District No. 874

Primary Registration District No. 6151B

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Vernon  
(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  
in this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Ray J 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 mas 4 1888  
(Month) (Day) (Year)

8. AGE: Years 60 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

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 Jan Day \_\_\_\_\_ Year 1942 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 Internal Hemorrhage  
Due to high Blood Pressure  
Due to mental strain

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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Francis W. Berry (M. D. or other) \_\_\_\_\_  
Address Moundville Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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

PHYSICIAN  
Underline the cause to which death should be charged statistically.

S-43201