S. No. 2
1-4-41
7-39
X28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 14 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24256

Registration District No. 102 | Primary Registration District No. 5416 | Registrar's No. 4174

1. PLACE OF DEATH:
(a) County: Dunklin
(b) City or town: Cardwell (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural Twp. 1 (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: 35
(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: WILLIAM FRANKLIN McDANIEL
3. (b) If veteran, name war: No
3. (c) Social Security No.: 441-16-2864
4. Sex: Male
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: Aug (Month) 19 (Day) 1884 (Year)
8. AGE: Years 57 Months 11 Days 12 If less than one day ..... hr. ..... min.
9. Birthplace: Bernie (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business .....
FATHER
12. Name: Robert McDaniel
13. Birthplace: Bernie, Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Abbie Breathouse
15. Birthplace: ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant: Lora Smith
(b) Address: Gulin, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Bernie Mo.
18. (a) Signature of funeral director: W. H. Howard
(b) Address: Leachville Ark
19. (a) Aug 5-42 (Date received local registrar) (b) M G Moore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1 year 1942 hour 10 minute 30 P. 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.

Immediate cause of death: Acute Myocardial failure — Duration
Due to: alcoholism and Epitemnt
Due to: Verdict of Coroner
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: None
Of autopsy: None

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: George I Gilmore M.D. (M. D. or other)
Address: Corner of Dunklin Kennett Mo

(Licensed Embalmer's Statement on Reverse Side)

1013

RECEIVED
District Health Office. No. 2,
District File Number 842-1063
Date Filed 8-12-42

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 H. H. Howard

Licensed Embalmer No. 3959

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
—8-21-41
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. 24256

Registration District No. 102 Primary Registration District No. 5416 Registrar's No.

1. PLACE OF DEATH:
(a) County: Dunklin
(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 years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Dunklin
(c) City or town: Burnie Mo (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: William Franklin McDaniel
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: S
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Aug (Month) 19 (Day) 1884 (Year)
8. AGE: Years 57 Months 11 Days If less than one day hr. min.
9. Birthplace: (City, town, or county) mo (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 8-3-42 (Month) (Day) (Year)
(c) Place: burial or cremation Burnie Mo
18. (a) Signature of funeral director H. H. Howard
(b) Address Leachville ark.
19. (a) 8-4-42 (Date received local registrar) (b) M S Moore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 1 year 1942 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from 19 to 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)
(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

SUPPLEMENTARY