

NO. 7-1
9-4-41
FILED MAR 11 1943

State File No.

Registration District No. 179

Primary Registration District No. 5-6-6-75668

Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Union Grove
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln 57
(c) City or town Rural 0
(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..... 0

3. (a) PRINT FULL NAME A. H. 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 w

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if

7. Birth date of deceased Aug 10 1865
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days - If less than one day hr. min.

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

10. Usual occupation Farmer

MOTHER FATHER

11. Industry or business
12. Name Thomas McDonald

13. Birthplace Lincoln Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Stacy
15. Birthplace Lincoln Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant E. R. McDonald

(b) Address Elsherry Mo
17. (a) Burial (b) Date thereof 2 14-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elsherry Mo

18. (a) Signature of funeral director W. W. Bradley
(b) Address Elsherry Mo

19. (a) Feb. 27-43 (b) W. H. Jackson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12
year 1943 hour 11-AM minute..... M.

21. I hereby certify that I attended the deceased from Feb 12 1943
that I last saw him live on Feb 11 1943
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Uremia and acute Dilatation of the heart

Due to.....
Old age

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 E. A. Hicks (M. D. or other)
Address Wray Date signed 2-27-43

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

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. _____

Signed: *W. H. Bradley*

Licensed Embalmer No. *3966*

P. O. Address: *Elmery*

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. 6865-

Registration District No. _____

Primary Registration District No. 5-667

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Clark Twp.

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Lincoln

(c) City or town Rural
(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 A J Mc Donald

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day _____ year 1943 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 at the date and hour stated above.

Immediate cause of death _____

4. Sex m 5. Color orr 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased Aug 10 -
(Month) (Day) (Year)

8. AGE: Years 77 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 _____

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 _____
(Burial, cremation, or removal) (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)

Due to old age

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

1312

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. A. Shields (M. D. or other) _____

Address Ray mo Date signed _____

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

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

