

FILED AUG 2 1943
Registration District No. 10320

Primary Registration District No. 6255

Registrar's No. _____

1. PLACE OF DEATH
(a) County Wayne
(b) City or town Wayne
(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 _____
In this community 60 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Rachel Adelia McCann
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 3 1859
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 6 If less than one day hr. _____ min.

9. Birthplace Hardin Co. Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business?
12. Name Jim Mills
13. Birthplace un known
(City, town, or county) (State or foreign country)
14. Maiden name un known
15. Birthplace un known
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James H. Kern
(b) Address Lawrence Mo

17. (a) Burial (b) Date thereof 7-12-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wesley Chapel

18. (a) Signature of funeral director Wesley Chapel
(b) Address Lawrence Mo

19. (a) 7-14-1943 (b) J. E. Bennett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 111
(a) State Missouri (b) County Wayne
(c) City or town Lawrence Rural Mo
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1943 hour 2:30 P minute _____ M.
21. I hereby certify that I attended the deceased from July 4
to July 9, 1943, to date, 1943;
that I last saw her alive on 7 death, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Regurgitation
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) 92

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?
While at work? _____ (Specify type of place)
(e) Means of injury 11
23. Signature Adam F. Wagner (M. D. or other) MD
Address Lawrence Mo Date signed 7-12-

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

RECORDS SECTION - MISSOURI STATE BOARD OF HEALTH - ST. LOUIS, MO. - PLEASE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Health Officer No. 4
District File Number 743-2470
Date Filed 7-31-43

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Wayne Primary Registration District No. 6205-

Registrar's No.

1. PLACE OF DEATH:

- (a) County Howards Rural
 (b) City or town Howards 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..... (Specify whether
years, months or days)3. (a) PRINT FULL NAME Rachel A McCorn

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

4. Sex F 5. Color or race W 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.....
(Month) (Day) (Year)8. AGE: Years 83 Months 7 Days 3 Unless than one day..... min.9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or 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) (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) (Date received local registrar)..... (b) (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 July
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 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 sta-
tistically.

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.....

WRITE PLAINLY—USE OF PENCILING, BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

986

S-26411

431