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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 7 1943

Registration District No. 3243

Primary Registration District No. 6231

Registrar's No.

1. PLACE OF DEATH:

(a) County Vermon

(b) City or town Rural

(c) Name of hospital or institution: Rt 10 & Richards Mo.

(d) Length of stay: In hospital or institution 17 years

In this community 17 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County Vermon

(c) City or town Rural

(d) Street No. RT 10 & R

(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Clifford E. McAtee

(b) If veteran, name war No

(c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20 year 1943 hour 6 minute 03 P. M.

21. I hereby certify that I attended the deceased from Sept 20 1943 to Sept 23 1943 that I last saw alive on Sept 20 1943 and that death occurred on the date and hour stated above.

4. Sex Male Color or race White

5. Color or race White

6. (a) Single, widowed, married, divorced 1

(b) Name of husband or wife Susana McAtee

(c) Age of husband or wife if alive 81 years

7. Birth date of deceased: Jan 28 - 1863

Immediate cause of death: Anterior sclerosis

Duration: 3 days

Due to: Anterior sclerosis

Other conditions: 83a!

8. AGE: Years 80 Months 7 Days 22

9. Birthplace: Grundy Co Mo.

10. Usual occupation: Farmer

11. Industry or business: Own Farm

12. Name: Clifford E. McAtee

13. Birthplace: Mo.

14. Maiden name: McAtee

15. Birthplace: Mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Thomas McAtee

(b) Address 4001 N. 1st St. Springfield Mo

17. (a) Date thereof Sept 23

(c) Place: burial or cremation Salers Cemetery

18. (a) Signature of funeral director J. A. Chesser

(b) Address 1115 S. 1st St. Vernon

19. (a) Sept 22, 1943 (b) McAtee & Charles

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature W. B. Primm Address Beersfield Mo. Date signed 9-21-43

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

MOTHER FATHER

1223

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 9-43-971

Date Filed 10-5-43

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 with the above constitutes grounds for revocation of license.)

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 100 **OCT** - 1943

Registration District No. 361 Primary Registration District No. 6231 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Vernon
 (b) City or town Rural Richland Twp.
 (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 Clifford E Mcatee
 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 married
 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 80 Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) mo

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)
 (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 5 Year 1943 Day 28 Hour _____ Minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____
 Due to _____
 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? _____

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

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

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

32796