

S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 7 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9971
Registrar's No. 1361

Registration District No. 199 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson,
(b) City or town Kansas City,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trinity Lutheran Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community as above, years, months or days)

2. USUAL RESIDENCE OF DECEASED: 997
(a) State Kansas, (b) County Miami
(c) City or town Lane
(If outside city or town limits, write "RURAL")
(d) Street No. R. F. D. #1
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Raymond McDougal,
3. (b) If veteran, name war NO. 3. (c) Social Security No. NO.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 26th.
year 1944 hour 12:18 minute AM.
21. I hereby certify that I attended the deceased from 9 21 44
3 26 to 3 26 44, 1944;
that I last saw him alive on 3 26 44, 1944;
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed,
6. (b) Name of husband or wife Mrs. Maude McDougal 6. (c) Age of husband or wife if alive X years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

Lobar Pneumonia
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy Lobar pneumonia

8. AGE: Years 66 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business X

MOTHER FATHER { 12. Name Charles W. McDougal
13. Birthplace West Virginia (State or foreign country)
14. Maiden name Eliza Jane Wells,
15. Birthplace West Virginia (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
108
Lobar pneumonia

16. (a) Informant Charles Alonzo McDougal

(b) Address Lane, Kansas, R. F. D. #1.

17. (a) Removal (b) Date thereof 3-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osawatomie, Kansas,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, Kansas City, Mo

19. (a) 3-27-44 (b) T. E. Brown
(Date received local registrar) (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 _____
(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 3
23. Signature T. E. Brown (M. D. or other)
Address 130 Prof. Bldg Date signed _____

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

Dr. C. C. Conover, 113434

Propts

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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 *John H. Hurley*

Licensed Embalmer No. *4050*

P. O. Address *Xenia, Ohio*

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.

APR 10 1944

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1361

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Lamar city
(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

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 _____

3. (a) PRINT FULL NAME Raymond McDougal
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 alive _____ years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 62 Months _____ Days _____ If less than one day, _____ min.

9. Birthplace unknown
(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)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and the death occurred on the date and hour stated above.
Immediate cause of death _____

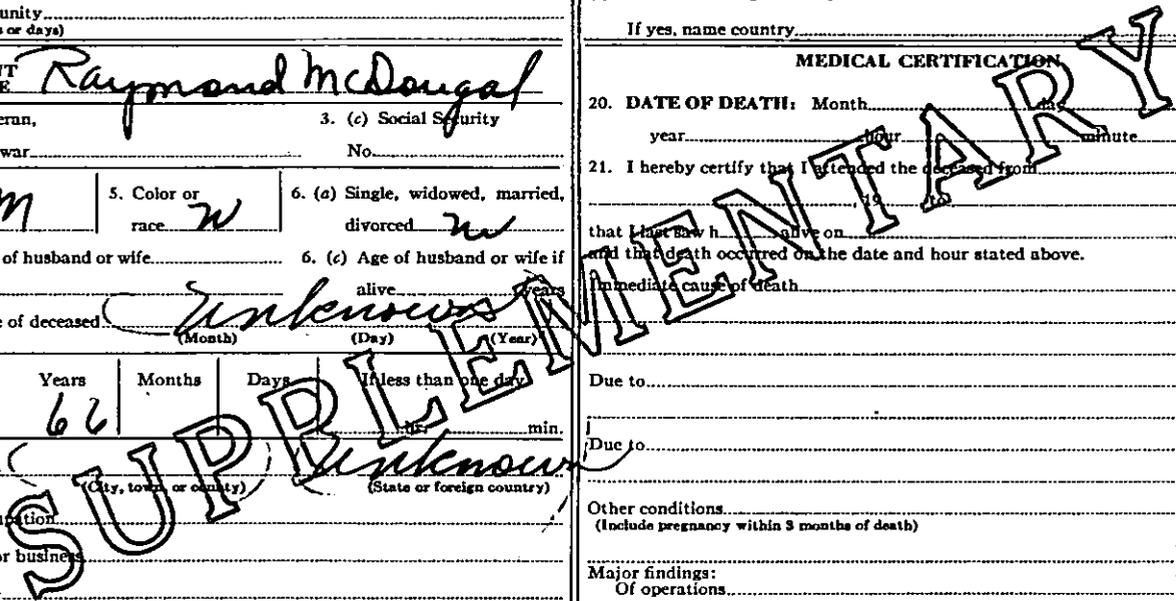
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

Duration _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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



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