

FILED APR 9 1944
Registration District No. _____

Primary Registration District No. 5356

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Loughane Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wilson Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 62 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Loughane Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME RILEY EVERETT McDANIEL

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Georgia McDaniel 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Jan 31 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 21 If less than one day hr. _____ min _____

9. Birthplace Dallas Co Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Nathan M Daniel

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name Francis Silbey

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Georgia McDaniel

(b) Address Loughane Mo.

17. (a) Burial (b) Date thereof Jan 15 1944
(Burial, cremation, or reinterment) (Month) (Day) (Year)

(c) Place: burial or cremation Wollard Cemetery

18. (a) Signature of funeral director L B Jones
(b) Address Buffalo Mo

19. (a) March 29 1944 (b) Miss D. H. Hoover
(Date received local registrar) (Registrar's signature)

1124 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16
year 1944 hour 5 minute 45 A 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 Pneumonia

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 3

23. Signature R B Jones (M. D. or other)
Address Buffalo Mo Date signed 1-11-

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

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

OCT 30 1951

MAR 12 1958

RECEIVED
District Office
District File No. 3-44-318
Date Filed 4-5-44
Officer No. 71

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 *Leonard B. Jones*
Licensed Embalmer No. *2508*

P. O. Address..... *Buffalo, Mo*

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.

Registration District No. 9

Primary Registration District No. 5256

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Rural Wilsonburg
(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

3. (a) PRINT FULL NAME Riley E. 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 M

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

7. Birth date of deceased Jan 3 (Month) (Day) (Year)

8. AGE: Years 62 Months 11 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 Jan 10
year 1944 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 Lobar pneumonia Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

10835