

FILED OCT 10 1944

Registration District No. _____

Primary Registration District No. 5551

Registrar's No. 79

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains, Missouri-R. F. D.
(c) Name of hospital or institution: Howell
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community 30 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
(c) City or town West Plains R. F. D.
(d) Street No. _____
(e) Citizen of foreign country? NO
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 7
year 1944 hour 3 minute 00 P. M.
21. I hereby certify that I attended the deceased from Jan. 1st,
1944 to Aug. 7th, 1944;
that I last saw her alive on July 15th, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death
Tuberculosis, Pul. Chron, Duration 2 or 3 yrs

Due to T.B. Infection
Due to _____
Other conditions _____
Major findings:
Of operations None
Of autopsy None made

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

3. (a) PRINT FULL NAME Treva Effie Osborn McDaniel

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Archie McDaniel 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased June 27, 1914
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>30</u>	<u>1</u>	<u>10</u>	hr. _____ min.

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

10. Usual occupation School Teacher

11. Industry or business _____

12. Name Jno. McDaniel

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

14. Maiden name Pearl Fowler

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

16. (a) Informant Mrs. Jno. McDaniel

(b) Address West Plains, Missouri

17. (a) B. (b) Date thereof 8-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ANY

18. (a) Signature of funeral director Robert

(b) Address West Plains, Missouri

19. (a) 9/10-44 (b) W. H. Phamburgh
(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?

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature W. H. Phamburgh (M. D. or other)
Address West Plains, MO. Date signed 8/23/44

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

600

1123

Phamburgh

RECEIVED

District Health Officer No. 5,

District File Number 1044500

Date Filed 10-9-44

DEC - 5 1945

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 A. D. Roberts

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.