

FILED NOV 8 1944  
Registration District No.

Primary Registration District No. 5844 Registrar's No.

1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Seneca Mo. Rural Seneca  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 5 Mi N.E. of Seneca  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 yrs (years, months or days)

3. (a) PRINT FULL NAME

Harry McNary

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex 0 male

5. Color or race white

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

6. (b) Name of husband or wife Mary McNary

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased October 15 1855  
(Month) (Day) (Year)

8. AGE:

Years 89 Months \_\_\_\_\_ Days 6  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Albany N. Y.  
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

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 James L. McNary

(b) Address Seneca Mo. RFD #2

17. (a) Burial (b) Date thereof Oct. 23 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Racine Mo. Burkhardt Cem

18. (a) Signature of funeral director K. Coltharp

(b) Address Seneca Mo

19. (a) Nov. 1st '44 (b) Dittie Norrio  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73  
(c) City or town Seneca Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5 Mi N. E.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22nd  
year 1944 hour 4 00 minute A M.

21. I hereby certify that I attended the deceased from July 20th  
1940 to Oct 13th 1944  
that I last saw him alive on Oct 13th 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis Duration 3 yrs

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 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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature John B. Roberts (M. D. or other) D.O.  
Address Seneca Mo Date signed \_\_\_\_\_

1352

10-26-44

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

RECEIVED NOV 6 1944  
District Health Officer No. \_\_\_\_\_  
District File Number 1044-218  
Date Filed NOV 6 1944

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 *Carley Thompson*

Licensed Embalmer No. *3259*

P. O. Address *Neesho Ms.*

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. 248 Primary Registration District No. 5844

1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Rural Seneca Jay  
(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 (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Harry McChary

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 un

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

7. Birth date of deceased Oct 15 1894  
(Month) (Day) (Year)

8. AGE: Years 89 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace unknown  
(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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Mrs BE Harris  
(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 Oct Day 26 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 \_\_\_\_\_

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)

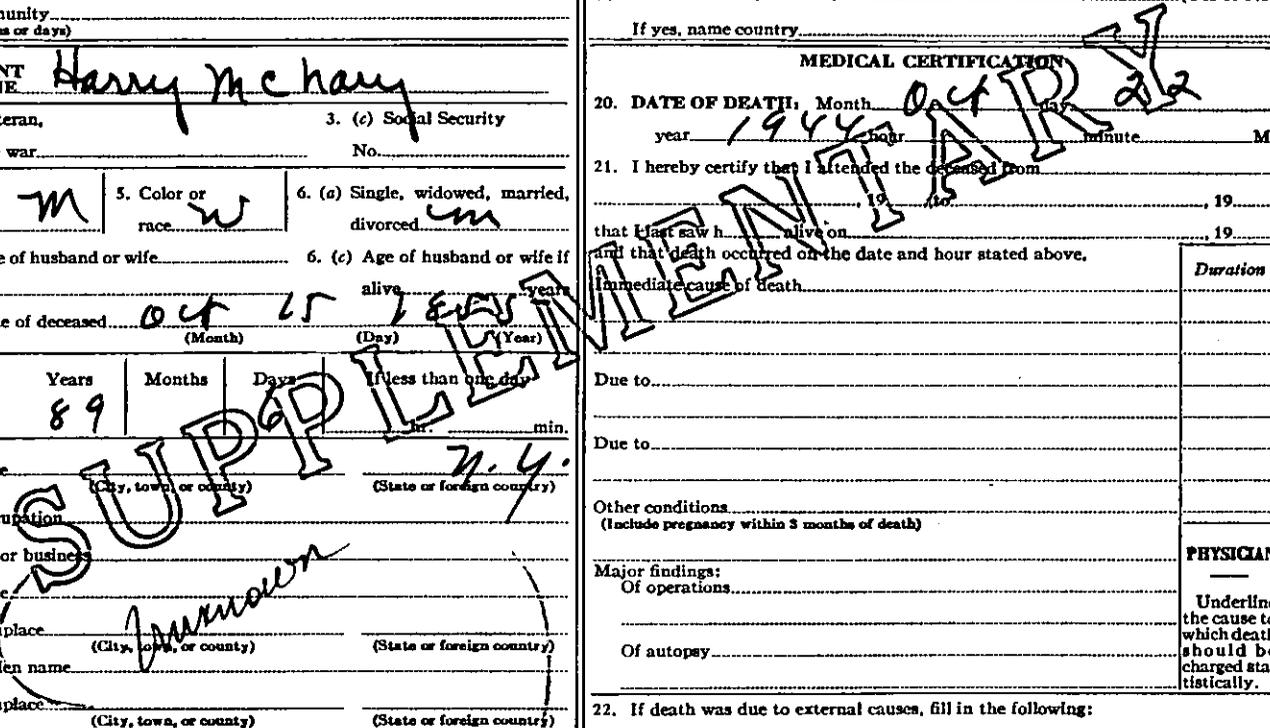
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



MOTHER FATHER

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

34907