

FILED DEC 13 1944

Registration District No. 14

Primary Registration District No. 4024

Registrar's No. 77

1. PLACE OF DEATH:

(a) County Barry  
 (b) City or town Cassville  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Barry County Hospital 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 days  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME QUOEHKA JUNE McGINLEY

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Ralph McKinley 6. (c) Age of husband or wife if alive 24 years  
 7. Birth date of deceased May 17 1922  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>22</u>	<u>6</u>	<u>0</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

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

12. Name Estel Eden  
 13. Birthplace Purdy Missouri  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Ruth Allred  
 15. Birthplace Purdy Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant Estel Eden  
 (b) Address Monett, Missouri

17. (a) Burial (b) Date thereof Nov. 19, 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation New Church

18. (a) Signature of funeral director Culbert Funeral Home  
 (b) Address Cassville Missouri

19. (a) Dec. 1, 1944 (b) Grace Williams  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry 5  
 (c) City or town Monett 13  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 310 North 6th Street 1  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17  
 year 1944 hour 4 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from 6-11  
 1944 to 11-17 1944  
 that I last saw her alive on 11-16 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Paralytic Steno  
 Due to following Hypertension 6 days  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 139  
 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? \_\_\_\_\_

23. Signature Franklin W. D. [Signature] (M. D. or other)  
 Address Monett Mo. Date signed 11/17/44

Duration 7 days  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 1244-1344

Date Filed DEC 12 1944

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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 Margaret Culver

Licensed Embalmer No. 4389

P. O. Address Cassville

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. 37040

Registration District No. 4

Primary Registration District No. 4024

Registrar's No. 77

1. PLACE OF DEATH:

(a) County Barry  
(b) City or town Cassville  
(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 Quella J. McGlinchey  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 May 17  
(Month) (Day) (Year)

8. AGE: Years 22 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 May day 17  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 \_\_\_\_\_

Duration

Due to \_\_\_\_\_  
Due to Pericardial infarction  
bleeding  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other)  
Date signed 5/20/46

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

SUPPLEMENTAL

MOTHER FATHER

L 3  
37040  
77

1944

S-37040