

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41547

State File No. _____

FILED JAN 15 1945
Registration District No. _____

Primary Registration District No. 5718

Registrar's No. 9

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

1. PLACE OF DEATH: *McDonard*
(a) County *South West City #1*
(b) City or town *South West City #1*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: *Primit Imp*
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State *MO* (b) County *McDonard*
(c) City or town *South West City*
(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 *Ella Melvina McKin*
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *Dec* day *5*
year *1944* hour *4* minute *P* M.
21. I hereby certify that I attended the deceased from *June*
1943 to *Dec 5*, 19*44*
that I last saw her alive on *Dec 5*, 19*44*
and that death occurred on the date and hour stated above.

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Widowed*
6. (b) Name of husband or wife *Joseph S. McKin* 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased *Aug 18 1878*
(Month) (Day) (Year)

Immediate cause of death: *Cerebral Hemorrhage* Duration *2 weeks*
Due to *Hypertension* *5 yrs*
Due to *Diabetes Mellitus* *8 yrs*
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

8. AGE: Years *66* Months *3* Days *18* If less than one day _____ hr. _____ min.

9. Birthplace *Greene Co Indiana*
(City, town, or county) (State or foreign country)
10. Usual occupation *Housewife*
11. Industry or business *Own Home*
12. Name *James Rea*
13. Birthplace *Greene Co Indiana*
(City, town or county) (State or foreign country)
14. Maiden name *Lydia J. Rea*
15. Birthplace *Greene Co Ind*
(City, town, or county) (State or foreign country)

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

16. (a) Informant *Oliver Marie Spitzer*
(b) Address *South West City MO*
17. (a) *Burial* (b) Date thereof *Dec 7-44*
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation *South West City MO*
18. (c) Signature *E.R. Fryatt*
(Funeral director)
(d) Address *Wentworth*
19. (a) *DEC 10 1944* (b) *John J. Nicholas*
(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 *2*
Signature *W.D. Fountain* (M. D. or other) _____
Address *Wentworth MO* Date signed *Dec 1*

1334

(Licensed Embalmer's Statement on Reverse Side)

DEC 23 1941

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..... *E. R. Pezzato*

Licensed Embalmer No. *3211*

P. O. Address..... *Genetta Ave*

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.