. S. No. 2
DM—8-43
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14864

FILED MAY 1 3 1945

Registration District No. [illegible] Primary Registration District No. 4549 Registrar's No.

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

1. PLACE OF DEATH:
(a) County North
(b) City or town Allendale (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County North
(c) City or town Allendale (If outside city or town limits, write "RURAL") 115
(d) Street No. (If rural, give location) R
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Almon Talmadge Daniels
3. (b) If veteran, name war World war #1
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Elsie Daniels
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased May (Month) 5 (Day) 1890 (Year)

8. AGE: Years 54 Months 11 Days 4 If less than one day hr. min.

9. Birthplace Allendale (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

MOTHER FATHER
12. Name Albert Ross Daniels
13. Birthplace Allendale (City, town, or county) Mo. (State or foreign country)
14. Maiden name Mary Elizabeth Mosley
15. Birthplace Grant City (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Elsie Daniels
(b) Address Allendale Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-45 (Month) (Day) (Year)
(c) Place: burial or cremation Kirk Cemetery
18. (a) Signature of funeral director Fred C. Dunfee
(b) Address Grant City, Mo.
19. (a) Apr. 13 1945 (Date received local registrar) (b) Maynard Rinehart (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 9 year 1945 hour 11 minute 30 A.M.
21. I hereby certify that I attended the deceased from 3-3- [illegible], 45, to 4-9- 45, 19[illegible]; that I last saw him alive on 4-9- 45; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypertensive Heart disease	3 hrs
Due to V	
Due to V	
Other conditions Diabetes (Include pregnancy within 3 months of death)	3 yrs
Major findings: Of operations V	
Of autopsy No	

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) V
(b) Date of occurrence V
(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? V (e) Means of injury V

23. Signature R. Ross [illegible] M.D. (M. D. or other)
Address Grant City Mo. Date signed 4-10-45

1385 (Licensed Embalmer's Statement on Reverse Side)

MAY 16 1945

RECEIVED
District Health Officer No. 11
District File Number
Date Filed

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 Jack C. Dunlee

Licensed Embalmer No. 3252

P. O. Address Grant City 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.