

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34408

State File No.

Registration District No. 245

Primary Registration District No. 5974

Registrar's No.

1. PLACE OF DEATH:

(a) County Dick

(b) City or town Walnut Grove R. Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Rural Jackson Township
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether)

In this community 40 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dick ⁸⁴

(c) City or town Walnut Grove Mo Rg Rural ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Jackson Township ⁰
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mertisha Clementine McDonald

3. (b) If veteran, name war nie

3. (c) Social Security No. nie

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 12
year 1945 hour 8 minute 40 A.M.

21. I hereby certify that I attended the deceased from July 15 - 45
1945 to Sept 11 1945;
that I last saw h. er alive on Sept 11 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia ✓ Duration _____

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife John A. McDonald died 9/11/1945

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

7. Birth date of deceased March 21 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>6</u>	<u>21</u>	hr. _____ min. _____

Due to after long illness

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

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

10. Usual occupation Housewife

11. Industry or business Housekeeper Farm Home

12. Name Charles Blair

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

14. Maiden name Elizabeth Durbin

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

16. (a) Informant Mrs. May Harman

(b) Address Walnut Grove Mo R

17. (a) Burial (b) Date thereof Sept 15 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Ridge Cemetery

18. (a) Signature of funeral director Gene A. Brown

(b) Address Walnut Grove Missouri

19. (a) Sept 15 1945 (b) Rose Stewart
(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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature J. W. Stewart M.D. (M. D. or other) _____

Address Walnut Grove Mo Date signed _____

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

1198

(Licensed Embalmer's Statement on Reverse Side)

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 Gene A. Brinn.....

Licensed Embalmer No. 2664.....

P. O. Address Nahant, Mass......

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. 285

Primary Registration District No. 5976

Registrar's No.

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Rural Jackson Twp
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

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 _____

3. (a) PRINT FULL NAME Mertilla C. McDonald

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him alive on _____, 19____; 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 wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased mar 2
(Month) (Day) (Year)

Immediate cause of death bronchial pneumonia or Hypostatic

Due to _____

Due to laying in bed on her back so long & a-was

Other conditions largely terminal
(Include pregnancy within 3 months of death)

8. AGE: Years 77 Months 6 Days _____
(If less than one day, hr. min.)

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

SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation _____

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 _____

(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)

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) (c) Means of injury

23. Signature Walter Cross (M. D. or other) _____

Address _____ Date signed 2/20-46

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

SUPPLEMENTARY

34408