

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27700

**FILED SEP 12 1946**

Registration District No. 193 Primary Registration District No. 4306 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County McDonald  
(b) City or town Goodman  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County McDonald  
(c) City or town Goodman, Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. RR (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Daniel Francis Hannan  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Grace Hannan 6. (c) Age of husband or wife if alive 50 years  
7. Birth date of deceased July 29, 1877  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 30  
year 1946 hour 4 minute 05 P. M.  
21. I hereby certify that I attended the deceased from 7/18/46, 19\_\_\_\_, to 7/30/46, 19\_\_\_\_;  
that I last saw him alive on 7/29/46, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral hemorrhage

8. AGE: Years 75 Months 00 Days 1 If less than one day hr. min.

Due to Hypertension + Arterio Sclerosis  
Had no speech for 4 years  
Due to This was his third attack  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Pittsburg Pa. (City, town, or county) (State or foreign country)  
10. Usual occupation merchant

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace unknown Ireland (City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown Canada (City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
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16. (a) Informant Grace Hannan  
(b) Address Goodman, Mo.  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-46 (Month) (Day) (Year)  
(c) Place: burial or cremation Howard Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Chas. W. Williams  
(b) Address Goodman, Mo.  
19. (a) Aug. 30, 1946 (Date received local registrar) (b) Max. Fred. W. Smith (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0  
23. Signature RC Johnson (M. D. or other) \_\_\_\_\_  
Address Neesh, Mo Date signed 8/12/46

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

26-5000

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**