DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 7 1946

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 34328

Registration District No. 272 Primary Registration District No. 4297 Registrar's No. 52

**1. PLACE OF DEATH:**
(a) County: Pemiscot
(b) City or town: Caster
(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: none (Specify whether years, months or days)
In this community: 36 yrs

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

3. (a) PRINT FULL NAME: Willard H McDaniel
3. (b) If veteran, name war: yes War II
3. (c) Social Security No.:
4. Sex: M
5. Color or race: White
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Lester McDaniel
6. (c) Age of husband or wife if alive: 40 years
7. Birth date of deceased: Oct (Month) 25 (Day) 1908 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 11 | 25 | hr. min. |

9. Birthplace: Walden (City, town, or county) Ind (State or foreign country)
10. Usual occupation: Truck Driver
11. Industry or business: Self
FATHER
12. Name: Thomas McDaniel
13. Birthplace: Ky (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Zantha Hemp
15. Birthplace: Dyersburg (City, town, or county) Tenn (State or foreign country)
16. (a) Informant: Mrs Leath McDaniel
(b) Address: Caster Mo
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof: 10-22-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Zion Steele Mo
18. (a) Signature of funeral director: J. L. Herman
(b) Address: Steele Mo
19. (a) Oct 30-46 (Date received local registrar) (b) L. R. Rhuman (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 20 year 1946 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from 10/20/46, 19..., to 10/20, 19 46 that I last saw him alive on 10/20, 19 46 and that death occurred on the date and hour stated above.

Immediate cause of death: Respiratory Failure. — Duration:
Due to:
Due to: Chronic Alcoholism. Possible Skull fracture.
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: N/A
Of autopsy:

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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):
(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? (Specify type of place)
While at work? (e) Means of injury: 2
23. Signature: J. M. Callahan (M. D. or other) DO
Address: Steele, Mo Date signed 10/28

279 (Licensed Embalmer's Statement on Reverse Side)

WHITE PAPER—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

10-46-226

NOV 26 1946

NOV 19 1946

MAY 15 1947

APR 4

## 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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Rush

State File No. 34328-46

Registration District No. 272 Primary Registration District No. 4397 Registrar's No. 52

**1. PLACE OF DEATH**

(a) County Pemiscot

(b) City or town Cooter
(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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Pemiscot

(c) City or town Cooter
(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 Willard H. McDaniel

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 Oct 25 1898 (Month) (Day) (Year)

8. AGE: Years 37 Months 12 Days If less than one day hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct Day 20 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from April 28, 1946, to Oct 20, 1946, that I last saw him alive on Oct 20, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to Chronic alcoholism

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J M Callaha (M.D. or D.O.)

Address Date signed

SUPPLEMENTARY

APR 1 - 1947
APR 1 - 1947
APR 14 1947