No. 2
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5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 17 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35870

Registration District No. 381 Primary Registration District No. 6183 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town M. AN.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: County Infirmary. 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 39 yrs. (Specify whether years, months or days)

In this community Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105

(c) City or town Milan
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME McNabb, Joe

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male 0

5. Color or race white

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Unknown (Month) (Day) 1893 (Year)

8. AGE: Years 53 Months Days If less than one day hr. min.

9. Birthplace Pollock. (City, town or county) Mo. 0 (State or foreign country)

10. Usual occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace 9 (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace 9 (City, town, or county) 9 (State or foreign country)

16. (a) Informant A. Drew

(b) Address Milan, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-46 (Month) (Day), (Year)

(c) Place: burial or cremation Milan

18. (a) Signature of funeral director Logan & Son

(b) Address Milan, Mo

19. (a) Sept. 30-1946 (Date received local registrar) (b) Mrs. H. B. Harris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16th year 1946. hour 4:30 a.m. minute M.

21. I hereby certify that I attended the deceased from May, 1940 to Sept. 16, 1946; that I last saw him alive on Sept. 5, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis.	40 yrs.
Due to: Bilateral Chronic Pneumonia Infantile Paralysis age 14.	
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 E. W. Simpson (M. D. or other) M.D.

Address Milan Date signed 9-16-46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 1
District File Number 10-46-1
Date Filed OCT-14-1946

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

Not Embalmed, 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.

No. 2B
M—3-45
1 X43880

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

State File No. Nov

Registration District No. 381 Primary Registration District No. 6183 Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Polk Twp. Milan
(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 Sullivan

(c) City or town Milan — Polk Twp.
(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 Joe McNabb

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Unk (Month) 1 (Day) 19 (Year)

8. AGE: Years 53 Months Days If less than one day hr. min.

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

10. Usual occupation Unknown

11. Industry or business invalid 40 yrs

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) Sept 30 - 1946 (Date received local registrar) (b) Mrs. H. B. Harris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 6 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

35870