

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED SEP 30 1947

Registrar's No. 213

Registration District No. 294

Primary Registration District No. 3656

## 1. PLACE OF DEATH:

- (a) County Randolph  
 (b) City or town Moberly  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Smiley Nursing Home 4  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 16 months  
 (Specify whether  
 In this community 17 months  
 years, months or days)

3. (a) PRINT FULL NAME WILLIAM WALLACE DAILY8. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed6. (b) Name of husband or wife Bliss Daily 6. (c) Age of husband or wife if alive 6 years7. Birth date of deceased March 6 1860  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
87 6 11 hr. min.9. Birthplace Keytesville Mo  
(City, town, or county) (State or foreign country)10. Usual occupation Retail Farmer

11. Industry or business

12. Name John Daily13. Birthplace Rock Spring Mo  
(City, town, or county) (State or foreign country)14. Maiden name Rock Spring Mo15. Birthplace Keytesville Mo  
(City, town, or county) (State or foreign country)16. (a) Informant Fred Riley(b) Address Keytesville Mo17. (a) Buried (b) Date thereof SEP 19 1947  
(Burial, cremation, or removal) (City, town, or county) (Day) (Year)(c) Place: burial or cremation Keytesville Mo18. (a) Signature of funeral director Walter E. Huber(b) Address Keytesville Mo19. (a) Sept 21-47 (b) Leah S. ...  
(Date received local registrar) (Registrator's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Chariton 21  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Keytesville Sup 2 miles west of  
 (If rural, give location) Keytesville  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17  
year 1947 hour 7 minute 30 M.21. I hereby certify that I attended the deceased from Sept 17/47  
such 24/47 to Sept 17/47  
that I last saw him alive on Sept 15/47  
and that death occurred on the date and hour stated above.Immediate cause of death nephritis 2 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature W. E. Huber M.D. (M. D. or other) \_\_\_\_\_Address Keytesville Mo Date signed 9/19/47

RECEIVED

District Health Officer No. 10

District File Number 1-47-13167

Date Filed SEP 29 1947

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 W. D. Garnett

Licensed Embalmer No. 3046

P. O. Address Keyesville, Tenn.

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, above space should be left blank.

D. H. Hahn

Registration District No. 294

Primary Registration District No. 3056

1. PLACE OF DEATH

(a) County Randolph  
(b) City or town Maebury  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Wm W. Daily

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 wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 6, 1917  
(Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

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 \_\_\_\_\_

MEDICAL CERTIFICATE

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1984 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. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_ chronic nephritis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_ 13/18

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 R E Hulse MD (M. D. or other) \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

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

MOTHER FATHER

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

5-32156