

S. No. 2
M-2-43
5-17-39
X35697

FILED OCT 8 1947
Registration District No. **252**

Primary Registration District No. **6193**

Registrar's No. **27**

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

1. PLACE OF DEATH:

(a) County Taney

(b) City or town Rural - dewan
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Franklin

(c) City or town Rural 997
(If outside city or town limits, write "RURAL")

(d) Street No. Jetho Ark 3
(If rural, give location)

(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ONA NELL DAILY

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5
year 1947 hour 7:30 minute A.M.

21. I hereby certify that I attended the deceased from Aug 15 1947 to Sept 5 1947
that I last saw her alive on Sept 4 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Rue Daily 6. (c) Age of husband or wife if alive years

7. Birth date of deceased July - 12 - 1881
(Month) (Day) (Year)

Immediate cause of death Mycocarditis Duration 1 mo.

8. AGE: Years 66 Months 1 Days 23 If less than one day hr. min.

Due to Don't know

9. Birthplace Waver Mo. 6
(City, town, or county) (State or foreign country)

Due to

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

Major findings: 9
Operations

12. Name Mr Matthew Good

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

13. Birthplace Don't know 9
(City, town, or county) (State or foreign country)

14. Maiden name Alinda Owen

15. Birthplace Don't know 9
(City, town, or county) (State or foreign country)

16. (a) Informant Thelma Cave

17. (a) Burial (b) Date thereof Sept 4 - 47
(Burial, cremation, or removal) (Month) (Day) (Year)

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 R. O. Wheelshel

(b) Address Brammer Mo

19. (a) 9-6-47 (b) J. E. Cornwell
(Date received local registrar) (Registrar's signature) on 9/6/47

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

23. Signature Harry T. Evans (M. D. or other) M. D.
Address Brammer Mo Date signed 9/11/47

RECEIVED

District Health Officer No. 61

District File Number 947-989

Date Filed SEP 30 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 Minnie L. Welch

Licensed Embalmer No. 2277

P. O. Address Branson Mo

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.