

S. No. 2
1-1/47
5-17-39

41227

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

National Office of Vital Statistics
FILED JAN 5 1948

Registrar's No. 187

Registration District No. 82

Primary Registration District No. 3017

1. PLACE OF DEATH:

(a) County... **Cooper**

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

(c) Name of hospital or institution... **St. Joseph Hospital.** 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution... **2 Weeks.**
(Specify whether in this community... **Most of life.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... **Missouri** (b) County... **Cooper** 27

(c) City or town... **Blackwater.** 0
(If outside city or town limits, write "RURAL")

(d) Street No... **Rural** 0
(If rural, give location)

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

If yes, name country: _____

3. (a) PRINT FULL NAME **Mrs. Carrie McHaven McMahan.**

3. (b) If veteran, name war: _____

3. (c) Social Security No. _____

4. Sex... **Female** 5. Color or race... **White**

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

6. (b) Name of husband or wife... **Jesse McMahan.** 6. (c) Age of husband or wife if alive... _____ years

7. Birth date of deceased... **May 4 1861**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
86	7	10	hr. _____ min.

9. Birthplace... **Selma Alabama**
(City, town, or county) (State or foreign country)

10. Usual occupation... **Housewife.**

11. Industry or business... **At home**

12. Name... **David DeHaven.**

13. Birthplace... **Virginia**
(City, town, or county) (State or foreign country)

14. Maiden name... **Mary Dobyns**

15. Birthplace... **Amite, Louisiana.**
(City, town, or county) (State or foreign country)

16. (a) Informant... **Mrs. Percy B. McMahan.**

(b) Address... **Blackwater, Mo.**

17. (a) **Burial** (b) Date thereof... **Dec. 16th/1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation... **Walnut Grove Cemetery**

18. (a) Signature of funeral director... **Goodman & Boller.**

(b) Address... **Boonville, Mo.**

19. (a) **12-15-47** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month... **December** day... **14**
year... **1947** hour... **9** minute... **p.** M.

21. I hereby certify that I attended the deceased from... **Dec. 3**, 19**47**, to... **Dec. 14**, 19**47**;
that I last saw her alive on... **Dec 14**, 19**47**;
and that death occurred on the date and hour stated above.

Immediate cause of death... **Broncho-Pneumonia** 3 days.

Due to: _____

Due to: _____

Other conditions... **Fracture right femur** 10 days
(Include pregnancy within 3 months of death)

Major findings: **Arteriosclerosis, Hypertension**

Of operations: _____

Of autopsy: **[Signature]**

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... **W.H. Ziegler** (M. D. or other) **M.D.**
Address... **Boonville Mo.** Date signed... **12/15/47**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 1-2-48

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.....

William R. Wood

Registered Apprentice No. 480

working under my personal supervision.

Signed.....

G. F. Roller

Licensed Embalmer No. 3062

P. O. Address Roanoke, Va

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.

Registration District No. 82

Primary Registration District No. 3017

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town Bronnille
(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)

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 _____

3. (a) PRINT FULL NAME

Carrie D. McMahon

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 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 _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 86 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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) _____ (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 _____ Year 1948 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 _____

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) Accident

(b) Date of occurrence 12-7-47

(c) Where did injury occur? Bronnille Cooper Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? St. Josephs Hospital

While at work? Patient (Specify type of place) (e) Means of injury Fall

23. Signature: W.H. Ziegler (M. D. or other) MD

Address: Bronnille Mo. Date signed 1-10-48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKES PERMANENT RECORD

SUPPLEMENTARY

41227