

S. No. 2
M-5-43
7-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 15 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42467**
Registrar's No. **47**

Registration District No. **241** Primary Registration District No. **5829**

1. PLACE OF DEATH: **New Madrid**
(a) County **Washington**
(b) City or town **Rural**
(c) Name of hospital or institution: **none**
(d) Length of stay: **23 yrs**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **New Madrid**
(c) City or town **Parma**
(d) Street No. **none**
(e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **Nathan Medcalf**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **—**
4. Sex **Male** 5. Color or race **colored**
6. (b) Name of husband or wife **Sally Medcalf** 6. (c) Age of husband or wife if alive **71** years
7. Birth date of deceased **April 15 1862**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **7** year **1947** hour **7** minute **—** A.M.
21. I hereby certify that I attended the deceased from **Sept 1**, 1946, to **Sept 7**, 1947 that I last saw him alive on **Sept 1**, 1947 and that death occurred on the date and hour stated above.
Immediate cause of death **Myocardial Regurgitation** Duration **1 yr**

8. AGE: Years **85** Months **4** Days **28** If less than one day — hr. — min.

Due to —
Due to —

9. Birthplace **Charlestown Miss.**
10. Usual occupation **Farmer**

Other conditions **Hypertension**
Major findings: Of operations — Of autopsy —

11. Industry or business —
12. Name **Joe Medcalf**
13. Birthplace **Alabama**
14. Maiden name **Betty Anderson**
15. Birthplace **Uniontown U.S.A.**

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? —
(d) Did injury occur in or about home, on farm, in industrial place, in public place? —

16. (a) Informant **Sally Medcalf**
(b) Address **Mardston, Mo.**
17. (a) **Removal** (b) Date thereof **Sept 10, 1947**
(c) Place: burial or cremation —

23. Signature **E E Jones** (M. D. or other) **0**
Address **Lilbourn, Mo** Date signed **Sept 7 47**

18. (a) Signature of funeral director **Walter R. Knight**
(b) Address **Malden, Mo.**
19. (a) **12-10-47** (b) **Ellen De Luba**

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

002

72
5
0
0

92B

RECEIVED

District Health Office No. 2

File Number 148-45

Date 1-8-28

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.....

Wallace R. Knight....., Registered Apprentice No. 482
working under my personal supervision.

Signed Thomas C. Knight.....

Licensed Embalmer No. 2189

P. O. Address Parma, 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.