FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JAN 17 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44187

Registration District No. 61

Primary Registration District No. 4107

Registrar's No. 67

1. PLACE OF DEATH:
(a) County: Cedar
(b) City or town: ElDorado Springs (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5 (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: Mo. (b) County: Cedar 20
(c) City or town: ElDorado Springs 1 (If outside city or town limits, write "RURAL")
(d) Street No. ..... 0 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Mary Alice O'Connor
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: Sept. (Month) 7 (Day) 1871 (Year)

8. AGE:

Years	Months	Days	If less than one day
76	3	13	..... hr. ..... min.

9. Birthplace: Springfield, (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business .....

FATHER
12. Name: Lindell Mynitt
13. Birthplace: Knoxville, (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name: Lue Ray
15. Birthplace: Arkansaw (City, town, or country) (State or foreign country)

16. (a) Informant: Burt Barnes
(b) Address: Stockton, Mo
17. (a) Omer (Burial, cremation, or removal) (b) Date thereof: 12 22 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Omer Cemetery
18. (a) Signature of funeral director: Chuck Neale
(b) Address: Stockton, Missouri
19. (a) 12-24-47 (Date received local registrar) (b) JC Brown (Registrar's signature) 53

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 21st year: 1947 hour: 9 minute: P.M.
21. I hereby certify that I attended the deceased from Dec 12, 1947 to Dec 19 1947 that I last saw her alive on Dec 19 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia — Duration .....
Due to: .....
Due to: .....
Other conditions (include pregnancy within 3 months of death): .....
Major findings: Of operations: 107
Of autopsy: .....

PHYSICIAN — Underline the cause of 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: I
23. Signature: C H Lumberworth (M. D. or other) DO
Address: El Dorado Spgs. Date signed: 12-24-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 13-47-3028
Date Filed 1-15-48

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 ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Melvin Church

Licensed Embalmer No. 3272

P. O. Address Stockton

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7-N

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 67

1. PLACE OF DEATH:

(a) County Cedar

(b) City or town El Dorado Springs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Twin Oaks Old People Home 5
(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
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 Mary A. O'Connor

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 Widowed

6. (b) Name of husband or wife Jas H Chamonor

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

7. Birth date of deceased Sept 7 (Month) (Day) 1871 (Year)

8. AGE: Years 76 Months 3 Days 3 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

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) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 21
year 1947 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...;
that I last saw h..... 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

44187