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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22035

FILED AUG 10 1948

Registration District No. 1 — Primary Registration District No. 3000 — Registrar's No. 201

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

1. PLACE OF DEATH:

(a) County: Adair

(b) City or town: Kirksville (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Grim-Smith Memorial Hospital (If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 4hrs. 47min. (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Sullivan 105

(c) City or town: Milan (If outside city or town limits, write "RURAL") 1

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

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME: David Griffin May

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: Male 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife

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

7. Birth date of deceased: July (Month) 29 (Day) 1948 (Year)

8. AGE: Years | Months | Days | If less than one day 4 hr. 47 min.

9. Birthplace: Kirksville (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Robert J. May
13. Birthplace: Milan (City, town, or county) Missouri (State or foreign country) 0

MOTHER
14. Maiden name: Cynthia Thompson
15. Birthplace: Altomont (City, town, or county) Missouri (State or foreign country) 0

16. (a) Informant: R J May
(b) Address: Milan Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-3-1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Oakwood - Milan

18. (a) Signature of funeral director: Schoenes
(b) Address: Milan Mo

19. (a) 8-3-48 (Date received local registrar) (b) Kate Lambert (Registrar's signature) 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1948 hour 10 minute 43 p.M.

21. I hereby certify that I attended the deceased from 5:56 July 29, 1948, to 10:43 July 29, 1948; that I last saw him alive on 7-29, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemorrhagic disease newborn	3 hrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 161

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) 0

While at work? (e) Means of injury

23. Signature: [signature] (M. D. or other) MD

Address: Kirksville, Mo. Date signed: 7/30/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-48-1424
Date Filed AUG 9 - 1948

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 not Embalmed Registered Apprentice No. working under my personal supervision.

Signed Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Milan - 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.