

FILED AUG 13 1948

State File No. _____

Registration District No. 299

Primary Registration District No. 6026

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town rural Carroll Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bee Fork R.R. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
In this community 4 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Reynolds
(c) City or town rural Carroll Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

NO FEE

(a) PRINT FULL NAME Baby Wayne McGee

(b) If veteran, name war _____ (c) Social Security No. _____

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

6. (b) Name of husband or wife Deceased (c) Age of husband or wife if 12 years alive 7 years

7. Birth date of deceased June 7 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 10 hr. min.

9. Birthplace Reynolds Mo (1)
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

12. Name _____

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

14. Maiden name Dorothy McGee

15. Birthplace Carroll Twp
(City, town, or county) (State or foreign country)

16. (a) Informant Dorothy McGee

(b) Address Reynolds, Mo. (2-14-48)

17. (a) Burial (b) Date thereof July 7
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation John Lay Cemetery

18. (a) Signature of funeral director Ray Frank Busker

(b) Address Busker, Mo

19. (a) _____ (b) C. W. Smith
(Date received local registrar) (Registrar's signature) 7/7/48

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17 day
year 1948 hour 11:00 AM minute 45 A.M.

21. I hereby certify that I attended the deceased from Nov. 1947
_____, 19____, to February 17, 1948

that I last saw him alive on February 17, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Bronchial

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 107

Of autopsy _____

Duration

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? _____

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

23. Signature L. L. Henson (M. D. or other) M.D.

Address Busker, Mo. Date signed 2-17-48

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. aug
Registrar's No. _____

Registration District No. 299

Primary Registration District No. 6026

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Rural
(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

3. (a) PRINT FULL NAME Wayne M. Lee

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased June 7 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (Unless than one day) hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) No.

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) C. M. Fitzpatrick (Registrar's signature)
(Date received local registrar)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 Year 1948 hour _____ minute 17 M.

21. I hereby certify that I attended the deceased from _____, 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) _____

(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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

5-23938