

FILED SEP 1 1949

STANDARD CERTIFICATE OF DEATH

State File No. 26550

Registration District No. 10356071-49

Primary Registration District No. 5417

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Reynolds  
 (b) City or town Gales 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.  
 In this community, years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds  
 (c) City or town Gales Rural  
 (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

Daniel Ray Mc Donald

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

4. Sex Male 5. Color or race W  
 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: 8 (Month) 49 (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 1 hr. 0 min.

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

10. Usual occupation Infant

11. Industry or business

12. Name Carmelus Daniel Mc Donald

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

14. Maiden name Lida Mc Donald

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

16. (a) Informant G. D. Mc Donald

(b) Address Gales Mo Star A-

17. (a) Burial (b) Date thereof 8-9-49  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garnes Cem.

18. (a) Signature of funeral director Bertha Kinschling

(b) Address Garnes Mo

19. (a) 8-9-1949 (b) Bertha Kinschling  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day ninth  
 year 1949 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from birth  
August 8, 1949, to 19,  
 that I last saw him alive on August 9, 1949,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Shunture infant

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) (c) Means of injury

Signature Carl T. H. ... M. D. or other

Address Shelton Bldg. Date signed 8-9-49

Duration

6 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED AUG 23 1949  
District Health Office No. 2,  
District File Number ~~849-2904~~  
Date Filed \_\_\_\_\_

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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 comply with the above constitutes grounds for revocation of license.)**

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