

FILED JUN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16056**
 BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **171**

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Callaway | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY Randolph | |
| b. CITY OR TOWN Fulton | | c. CITY OR TOWN Moberly 0863 | |
| c. LENGTH OF STAY (in this place) 374 | | d. STREET ADDRESS (If rural, give location) 811 McKinley Ave | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital #1 | | | |

| | | | | | |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) EDNA b. (Middle) MCDONALD c. (Last) MCDONALD | | | 4. DATE OF DEATH (Month) (Day) (Year) MAY 21 1950 | | |
|---|--|--|--|--|--|

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|-----------------|---------------------------|---|-------------------------------------|---|--|---|
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W | 8. DATE OF BIRTH Feb 16-1871 | 9. AGE (In years less birthday) 79 | 10. UNDER 1 YEAR Months 3 Days 5 | 11. UNDER 24 HRS Hours Min. |
|-----------------|---------------------------|---|-------------------------------------|---|--|---|

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|---|--|---|--|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Work | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Huntsville Mo | | 12. CITIZEN OF WHAT COUNTRY USA | |
|---|--|---|--|--|--|--|--|

| | | | | | | | |
|---|--|--|--|-----------------------------------|--|--|--|
| 13a. FATHER'S NAME Henry Jackson | | 13b. MOTHER'S MAIDEN NAME Nancy Ellen Brady | | 14. NAME OF HUSBAND OR WIFE _____ | | | |
|---|--|--|--|-----------------------------------|--|--|--|

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) dk | | 16. SOCIAL SECURITY NO. dk | | 17. INFORMANT'S SIGNATURE OR NAME H. Jackson ADDRESS Columbia Mo | | | |
|--|--|-----------------------------------|--|--|--|--|--|

| | | | | | | | |
|---|--|---|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) chr myo carditis | | | | INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|---|--|--|--|----------------------------------|--|

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

| | | | | | | | |
|--|--|------------------|--|------------------|--|-------|--|
| II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death. J.B. pulm decompensation | | DUE TO (b) _____ | | DUE TO (c) _____ | | 4222A | |
|--|--|------------------|--|------------------|--|-------|--|

| | | | | | | | |
|------------------------------|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------------|--|--|--|--|--|---|--|

| | | | | | |
|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____ | |
|--|--|--|--|---|--|

| | | | | | |
|---|--|--|--|----------------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | |
|---|--|--|--|----------------------------------|--|

22. I hereby certify that I attended the deceased from **5-16**, 19**50**, to **5-21**, 19**50**; that I last saw the deceased alive on **5/21**, 19**50** and that death occurred at **7:25** m., from the causes and on the date stated above.

| | | | | | |
|---|--|---|--|---------------------------------|--|
| 23a. SIGNATURE M. J. Miller M.D. (Degree or title) | | 23b. ADDRESS State Hospital Fulton | | 23c. DATE SIGNED 5-21-50 | |
|---|--|---|--|---------------------------------|--|

| | | | | | | | |
|---|--|------------------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE May 23-1950 | | 24c. NAME OF CEMETERY OR CREMATORY Jackson Cemetery | | 24d. LOCATION (City, town, or county) (State) Randolph County Mo | |
|---|--|------------------------------|--|--|--|---|--|

| | | | | | |
|---|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. May 21-1950 | | REGISTRAR'S SIGNATURE Maretha Lawrence 426 | | 25. FUNERAL DIRECTOR'S SIGNATURE Tom B. Patton ADDRESS Huntsville Mo | |
|---|--|--|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

District File Number
District Health Officer No. 9
RECEIVED
MAY 30 1950

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Tom B. Patton

Licensed Embalmer No. 3914

P. O. Address Huntsville, Ind

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.