

FILED SEP 5 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29196

BIRTH NO. _____		REG. DIST. NO. 324		PRIMARY REG. DIST. NO. 6093		Registrar's No. 19 162	
1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural c. LENGTH OF STAY (In this place) 15 Yrs.				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Marshall 0970			
d. FULL NAME OF HOSPITAL OR INSTITUTION Saline County Home				d. STREET ADDRESS (If rural, give location) R.F.D. North of Marshall, Mo.			
3. NAME OF DECEASED (Type or Print) Ida		a. (First)		b. (Middle)		c. (Last) McMahan	
4. DATE OF DEATH August 23- 1951		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH Do Not Know		9. AGE (In years last birthday) 92		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) TXAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Frank McMahan		13b. MOTHER'S MAIDEN NAME Rachel Foster	
14. NAME OF HUSBAND OR WIFE Mrs. Bessie Bryan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Bessie Bryan-Marshall, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia INTERVAL BETWEEN ONSET AND DEATH 3 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 10 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES ☐ NO ☐		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21b. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)		21c. HOW DID INJURY OCCUR?		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. I hereby certify that I attended the deceased from July 4, 1949 to Aug 23, 1951 , that I last saw the deceased alive on Aug 23, 1951 , and that death occurred at 1:50 P.M. , from the causes and on the date stated above.		22a. SIGNATURE W. D. Marshall (Degree or title)		22b. ADDRESS Marshall, Mo.	
22c. DATE SIGNED 8/24/51		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/25/51		23c. NAME OF CEMETERY OR CREMATORY Arrow Rock Cem	
23d. LOCATION (City, town, or county) (State) Arrow Rock - Mo.		23e. DATE REC'D BY LOCAL REG. Aug 25 1951		23f. REGISTRAR'S SIGNATURE Sidney F. Gray		23g. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Lealie Surgery Marshall, Mo.	

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

RECEIVED 9-4-51
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 9-4-51 _____

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

J. Leslie Swenson
Licensed Embalmer No. 3235

P. O. Address *Marshall, W*

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.