

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25917**

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023** Registrar's No. **L**

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Henry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Urich MO	
c. LENGTH OF STAY (In this place) One week		d. STREET ADDRESS (If rural, give location) 0420	
d. FULL NAME OF HOSPITAL OR INSTITUTION Clinton General Hospital			

3. NAME OF DECEASED (First) Solon (Middle) - (Last) McDaniel		4. DATE OF DEATH (Month) 8 (Day) 18 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Never	8. DATE OF BIRTH June 30, 1869
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. BIRTHPLACE (City and State or Foreign Country) U. S. A.
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13a. FATHER'S NAME James R. McDaniel	13b. MOTHER'S MAIDEN NAME Sarah Jane Warren	14. NAME OF HUSBAND OR WIFE
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 W.S. McDaniel ADDRESS Topoka, Kansas

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 12 hr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Heart disease DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201			

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) m.	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 **Aug 1, 1955**, to **Aug 19, 1955**, that I last saw the deceased alive on **Aug 19, 1955**, and that death occurred at **5 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Deputy or title)	23b. ADDRESS Clinton MO	23c. DATE SIGNED 8-20-55
24a. BURIAL OR CREMATION, REMOVAL (Specify)	24b. DATE Aug 26-1955	24c. NAME OF CEMETERY OR CREMATORY Mullins
24d. LOCATION (City, town, or county) (State) Urich MO		

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 8-20-55 Florence Adams	25. FUNERAL DIRECTOR'S SIGNATURE W.J. Brown ADDRESS Urich MO
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed R R Kenney

Licensed Embalmer No. 3099

P. O. Address Clinton 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.