

FILED JAN 7 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44017

STATE FILE NUMBER

Registration District No. 120

Primary Registration District No. 4194

Registrar's No. 159

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Gentry</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gentry</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Albany</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>McFall</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gentry County Memorial Hosp.</b>			Length of stay in lb <b>15 days</b>		d. STREET ADDRESS <b>South St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Nelson</b> Last <b>McDaniel</b>				4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1957</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 12 1885</b>		9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (City and state or country) <b>Harrison County Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13a. FATHER'S NAME <b>W.P. McDaniel</b>			13b. MOTHER'S MAIDEN NAME <b>Susie Matkins</b>			14. NAME OF HUSBAND OR WIFE <b>Leora Shaughnessy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Eldon McDaniel</b>			Address <b>Kansas City, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of stomach</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____							<b>151X</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Albany</b>		COUNTY <b>Gentry</b>		STATE <b>Mo</b>	
21. I attended the deceased from <b>12-8-57</b> to <b>12-30-57</b> and last saw him alive on <b>12-30-57</b> Death occurred at <b>6:15 P</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Frank H. Rose M.D.</b>				22b. ADDRESS <b>Albany, Mo.</b>			22c. DATE SIGNED <b>12-31-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Jan. 2, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Matkins</b>		23d. LOCATION (City, town, or county) (State) <b>Harrison County Mo.</b>				
24. FUNERAL DIRECTOR <b>Clifford Brooks - Albany, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>1-2-1958</b>		26. REGISTRAR'S SIGNATURE <b>Mr. J. W. Bair</b>			

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.  
 Governor, coroner, etc.: this certificate only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

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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 me....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Donald E. Cochell.....

Licensed Embalmer No. 4868.....  
P. O. Address Albany, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.