

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032449  
STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 133 Primary Registration District No. 4206 Registrar's No. 125

1. PLACE OF DEATH a. COUNTY <b>Harrison</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Harrison</b>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>New Hampton, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>New Hampton,</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>Home in New Hampton 24yrs.</b>			Length of stay in lb		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>Cordia</b> Middle <b>Mae</b> Last <b>McDaniel</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>24,</b> Year <b>1958</b>											
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 19, 1887</b>		9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>In own home</b>		11. BIRTHPLACE (City and state or country) <b>Harrison Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>								
13a. FATHER'S NAME <b>Dr. B. M. Sutton</b>			13b. MOTHER'S MAIDEN NAME <b>Eva L. Elliot</b>			14. NAME OF HUSBAND OR WIFE <b>James O. McDaniel</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>James O. McDaniel New Hampton, 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>Chronic interstitial nephritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <b>Senile Psychosis</b>		DUE TO (c) <b>Hypertension in</b>		6 mo.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							446X			5 yrs					
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 WORK <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 COUNTY STATE		
21. I attended the deceased from <u>Oct 1956</u> to <u>9-24-58</u> and last saw her alive on <u>9-5-58</u> Death occurred at <u>4:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <b>R. L. Green, D.O.</b>				22b. ADDRESS <b>New Hampton Mo</b>				22c. DATE SIGNED <b>9-25-58</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 26, 1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burris</b>			23d. LOCATION (City, town, or county) (State) <b>Harrison Co. Mo.</b>								
24. FUNERAL DIRECTOR ADDRESS <b>W. St. N. &amp; Son New Hampton Mo</b>				25. DATE RECD. BY LOCAL REG. <b>9-25-1958</b>		26. REGISTRAR'S SIGNATURE <b>Gella Mayes</b>									

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 .....  
Signature of Student Embalmer

Signed *W. G. Noble* .....

Licensed Embalmer No. *2904*  
P. O. Address *New Hampshire*

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.