

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035679

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 239

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jefferson City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Hospital No. 1</u>		Length of stay in 1b <u>5yr 5mo</u>	d. STREET ADDRESS (If outside, give location) <u>0267 State Prison</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles William McDaniel</u>			4. DATE OF DEATH Month Day Year <u>October 23, 1958</u>
5. SEX <u>Male 0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/6/1872</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith and Farmer</u>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>86</u> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cass County Mo. 0</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. NAME OF HUSBAND OR WIFE	
13a. FATHER'S NAME <u>Malon McDaniel</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Abrams</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>St. Hospital No. 1, Fulton, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>4200</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic nephritis</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year o.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. X Attended the deceased from <u>May 5, 1953</u> to <u>Oct. 23, 1958</u> and X <u>XXXXXXX</u> Death occurred at <u>8:05 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James K. Pitterhouse M.D. 0</u>		22b. ADDRESS <u>Fulton, State Hospital No. 1; Missouri</u>	
22c. DATE SIGNED <u>10/23/1958</u>		23. NAME OF CEMETERY OR CREMATORY <u>anatomical Board Columbia mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-28-58</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Columbia mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>J. O. Roberts Columbia mo</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 28. 1958</u>	
26. REGISTRAR'S SIGNATURE <u>Maritta Lawrence</u>			

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All diseases in Part I must be causally related.

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

Licensed Embalmer No.

P. O. Address

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.