ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-043340
STATE FILE NUMBER

AMENDED

Registration District No. 340 Primary Registration District No. 3075 Registrar's No. 89

FILED NOV 22 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

1. PLACE OF DEATH
a. COUNTY Stoddard
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dexter — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Stoddard
c. CITY OR TOWN Dexter — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 212 East St. Francis — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Marion Middle Eli Last McDaniel

4. DATE OF DEATH Month Nov. Day 13, Year 1961

5. SEX Male

6. COLOR OR RACE White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 1-8-1878

9. AGE (last birthday) 83 — IF UNDER 1 YEAR Months 10 Days 5 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (City and state or country) Russellville, Ark.

12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME Ulyssis McDaniel

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE Sallie B. McDaniel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Mrs. Sallie B. McDaniel, Dexter, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hypostatic Pneumonia	48 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral Thrombosis	2 wks.
DUE TO (c)	Cerebro-sclerosis	Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE 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. I attended the deceased from Nov. 9, 1961, to Nov. 13, 1961 and last saw him alive on Nov. 11, 1961
Death occurred at 8:00 A. M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Gerald W. Dickerson D.O.

22b. ADDRESS E. Stoddard St. Dexter, Mo.

22c. DATE SIGNED 11/14/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 11-15-61

23c. NAME OF CEMETERY OR CREMATORY Dexter

23d. LOCATION (City, town, or county) (State) Dexter, Missouri

24. FUNERAL DIRECTOR ADDRESS Rainey Funeral Home, Dexter, Mo.

25. DATE RECD. BY LOCAL REG. 11/16/61

26. REGISTRAR'S SIGNATURE Velma V. Jenkins

(Licensed Embalmer's Statement on Reverse Side)

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 Raymond L. Duffie

Licensed Embalmer No. 4798

P. O. Address Berne, N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.