FILED FEB 14 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2723
Do not use this space.

1. PLACE OF DEATH
(a) County Henry — Registration District No. 349
(b) Township Springfield — Primary Registration District No. 5500 — Registered No. 2
(c) City Clinton — (d) Street No. 1 — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 12 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alice H. Daniels
(a) Residence, No. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: Jerry D. Daniels
6. DATE OF BIRTH (MONTH, DAY AND YEAR): 7-7-1880
7. AGE — YEARS: 60 — MONTHS: 6 — DAYS: 19 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.:
9. Industry or business in which work was done, as saw mill, bank, etc.: Housewife
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Independence Mo.

FATHER
13. NAME: Ira Toler
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Virginia

MOTHER
15. MAIDEN NAME: Bridgett Dillon
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ireland

17. INFORMANT (ADDRESS): Sim Chandler Clinton Mo.
18. BURIAL, CREMATION, OR REMOVAL: Burial
PLACE Lockhaven, Mo. DATE Jan 28 1941
19. FUNERAL DIRECTOR (ADDRESS): Fred Wilkinson Clinton Mo
20. FILED Jan 28 1941 Mrs. Edith J. Simpson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 1-26 1941
22. I HEREBY CERTIFY, That I attended deceased from 3-30 1940, to 1-26 1941
I last saw h. alive on 1-23 1941. Death is said to have occurred on the date stated above, at 2:30 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis	?
Other contributory causes of importance: Chronic Nephritis	Aug 1940

Name of operation: Date of:
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) James L. Smith M. D.
(Address) Clinton Mo

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should stat CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importan

RECEIVED
District Health Officer No. 7,
District File Number 2-41-164
Date Filed 2-3-41

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by.....Registered Apprentice No.....

working under my personal supervision.

Signed Fred Wilkerson

Licensed Embalmer No. 278

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

o. 2B
-21-40
X22855

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2723

Registration District No. 349 Primary Registration District No. 5500 Registrar's No.

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Springfield T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Henry
(c) City or town Rural
(If outside city or town limits write "RURAL")
(d) Street No. Springfield Twp
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Alice H. Daniels
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Wi

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 60 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Jan 28 1941 (Date received local registrar) (b) Mrs. Edith J. Simpson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 26
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature James O. Smith (M. D. or other)
Address Clinton Mo Date signed

SUPPLEMENTARY