

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 6164

1. PLACE OF DEATH:

(a) County St. Louis, Mo
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Barnes Hospital, O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 days (Specify whether
in this community 30 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois Co
(c) City or town St. Francois Co
(If outside city or town limits, write "RURAL")
(d) Street No. NR (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thela Marie McDaniel

3. (b) If veteran, name war _____ 3. (c) Social Security No. 1-1-1

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Paul McDaniel 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 26 1922
(Month) (Day) (Year)

8. AGE: Years 22 Months 10 Days 19 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name William O. Dell

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

14. Maiden name Julia Jane Taylor

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

16. (a) Informant Paul C. McDaniel

(b) Address 1504 Air Cone

17. (a) Religious (b) Date thereof 7 19 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park View

18. (a) Signature of funeral director W. J. ...
(b) Address Sparks and Co. ...

19. (a) JUL 17 1945 (Date received local registrar) (b) W. J. ... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15 year 1945 hour 8 minute 50 P M.

21. I hereby certify that I attended the deceased from June 15, 1945, to July 15, 1945, that I last saw her alive on July 15, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Hypertensive cardiovascular disease
Bronchopneumonia

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations: _____
Of autopsy: _____

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? _____

While at work 7th St. ... (Specify type of job) of injury ...
23. Signature William C. Rablow (M. D. or other) _____
Address Barnes Hospital Date signed _____

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

MOTHER, FATHER

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

..... Registered Apprentice No.

..... working under my personal supervision.

Signed

Edward Sparks

Licensed Embalmer No. *4287*

P. O. Address *Flat River, 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 this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Aug6160Registration District No. 318Primary Registration District No. 1003Registrar's No. 6160

1. PLACE OF DEATH:

- (a) County.....St. Louis
 (b) City or town.....St. Louis
 (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)

3. (a) PRINT
FULL NAMEThela M. McDaniel3. (b) If veteran,
name war.....3. (c) Social Security
No.....

4. Sex F 5. Color or race w
 6. (a) Single, widowed, married,
divorced Married
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive 26 years
 7. Birth date of deceased Aug 26 1922
 (Month) (Day) (Year)

8. AGE: Years 22 Months _____ Days _____ If less than one day
hr. _____ min. _____9. Birthplace.....mo
(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) AUG 1 1945 (Date received local registrar)
J. F. Bredeek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
 (c) City or town.....
 (If outside city or town limits, write "RURAL")
 (d) Street No.....
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Year 1945
 hour _____ minute _____ M. _____
 21. I hereby certify that I attended the deceased from _____
 to _____, 19____;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 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 sta-
tistically.

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?
 While at work?..... (Specify type of place)
 (e) Means of injury.....

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

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

SUPPLEMENTARY

1945

S-22236

