

FILED FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

4109

State File No.

Registration District No. 775

Primary Registration District No. 6020-a

Registrar's No. 5

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 945
05
 (c) City or town _____ 05
(If outside city or town limits write "RURAL")
 (d) Street No. _____
(If rural, give location) 0
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Blyde Curtis McDaniel
 8. (b) If veteran, 5 3. (c) Social Security No. 5
 name war _____
 4. Sex S 5. Color or race S 6. (a) Single, widowed, married, divorced 3
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 26 or 1896
(Month) (Day) (Year)
 8. AGE: Years 43 Months 7 Days 18 If less than one day _____ hr. _____ min.
 9. Birthplace St. Genevieve Co. Mo
(City, town, or county) (State or foreign country)
 10. Usual occupation miner
 11. Industry or business _____
 12. Name Jackson McDaniel
 13. Birthplace St. Genevieve Co. Mo
(City, town, or county) (State or foreign country)
 14. Maiden name Esther Adams
 15. Birthplace St. Genevieve Co. Mo
(City, town, or county) (State or foreign country)
 16. (a) Informant Jesse McDaniel
 (b) Address Esther Mo
 17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Wood Lawn
 18. (a) Signature of funeral director Baldwell Bros
 (b) Address Flat River Mo
 19. (a) Jan 14 1941 (b) N. W. Hawkins
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month Jan day 13
 year 1941 hour 11 minute 05 P.M.
 21. I hereby certify that I attended the deceased from Jan 13, 1941, to Jan 13, 1941;
 that I last saw him alive on Jan 13, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
 Due to _____
 Due to _____
 Other conditions Intestinal tumor
(Include pregnancy within 3 months of death)
 Major findings: or absent
 Of operations none
 Of autopsy none
 Duration 2 days
 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) none
 (b) Date of occurrence none
 (c) Where did injury occur? none
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
698 none
(Specify type of place)
 While at work? none (e) Means of injury none
 23. Signature Van W. Taylor (M. D. or other) D
 Address Bonne Terre Mo Date signed 1/14/41

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

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108

SM

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

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 4109

Registration District No. 775-

Primary Registration District No. 6020A

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Bonne Terre
(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 _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL.")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Clyde Curtis McDaniel

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 13 year 1945 hour _____ minute _____ M.

4. Sex _____ 5. Color or race _____

6. (a) Single, widowed, married, divorced _____

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) _____

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

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>7</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death Lobar Pneumonia Duration 108

Due to _____

Due to _____

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

10. Usual occupation _____

11. Industry or business _____

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) _____

Other causes Intermittent Jaundice
(Include pregnancy within 3 months of death)

Major findings: abscess

Of operations: N. M. D.

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 Wm W Taylor (M. D. or other) _____

Address Bonne Terre Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41097

Registration District No. 775-

Primary Registration District No. 6020a

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Francis
(b) City or town Bonne Terre
(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 NAME Clyde Curtis Mc Daniel

3. (b) If veteran, name war _____
3. (c) Social Security No. 193-02-8856

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

6. (b) Name of husband or wife Jessie Mae McDaniel
6. (c) Age of husband or wife if alive 41 year

7. Birth date of deceased May 26 1897
(Month) (Day) (Year)

8. AGE: Years 44 Months 10 Days 7 If less than one day _____ min. _____

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

10. Usual occupation miner

11. Industry or business _____

12. Name Jackson Mac Daniel
13. Birthplace St. Genevieve Mo
(City, town, or county) (State or foreign country)

14. Maiden name Esther Jones
15. Birthplace St. Genevieve Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Jessie Mae McDaniel
(b) Address Esther Mo

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (City or town) (County) (State) (Year)
(c) Place: burial or cremation Woodlawn Cemetery

18. (a) Signature of funeral director Baldwell Bue
(b) Address High River Mo

19. (a) _____ (b) T.W. Hawkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francis
(c) City or town Cather
(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 1 day 13
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that 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 _____

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 Van W. Taylor (M. D. or other) _____
Address _____ Date signed _____

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

MISSOURI STATE BOARD OF HEALTH

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.