

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FEB 15 1940  
Registration District No. 564

Primary Registration District No. 5758

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Miller  
(b) City or town Jacksonia, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: County Home, Equality, Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 years  
(Specify whether years, months or days) 5 1/2

3. (a) PRINT FULL NAME GEORGE DEXTER MC TALLEY

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased July 18 1865  
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 10 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John McTalley 9  
13. Birthplace unknown 6  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name unknown 1  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Milton Cooper  
(b) Address Jacksonia, Mo.

17. (a) Burial (b) Date thereof 1/29/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Manchester, Mo.  
18. (a) Signature of funeral director E. L. Baser  
(b) Address Idonia

19. (a) 1-28-40 (b) L. M. Garner Hill  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Miller  
(c) City or town Rural - Brunley, Mo.  
(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.? Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28  
year 1940 hour 3 minute 9 M.

21. I hereby certify that I attended the deceased from Oct 1938, 19\_\_\_\_, to Jan, 1940;  
that I last saw him alive on Jan 24, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Bronchitis Duration 7 days  
Due to myocarditis & arteriosclerosis, severe years  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 938

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? \_\_\_\_\_

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

23. Signature L. M. Garner (M. D. or other) 1  
Address Jacksonia Date signed 1-28-40

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

RECEIVED

Miller County Health Dep't.

County File Number 2-40

Date Filed 2-12-40

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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.**