DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28965

SEP 23 1940

Registration District No. 477 Primary Registration District No. 42905 Registrar's No. 25

1. PLACE OF DEATH:

(a) County Lewis La. Bell

(b) City or town Lewistown
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.F.D. #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓ 2 (Specify whether

In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis

(c) City or town Lewistown (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. #2
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary McNally

3. (b) If veteran, name war ✓

3. (c) Social Security No. [illegible]

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife Onry McNally

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased June (Month) 28 (Day) 1866 (Year) 1862

8. AGE: Years 78 Months 1 Days 9 If less than one day ..... hr. ..... min.

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

10. Usual occupation at Home

11. Industry or business

FATHER
12. Name Martin Lovell
13. Birthplace Ireland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Kate McDonald
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jim McNally
(b) Address Lewistown Mo

17. (a) St Patrick Cem Lewis (Burial, cremation, or removal) (b) Date thereof 8 (Month) 9 (Day) 1940 (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director James A Coder
(b) Address Lewistown Mo

19. (a) Aug 8 - 1940 (Date received local registrar) (b) H. W. Jennings M.D. (Registrar's signature) A.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7th. year 1940 hour 6 am minute ..... M.

21. I hereby certify that I attended the deceased from Aug 28 1940 Aug 7 1940, 19..., to Aug 7 1940, 19...; that I last saw her alive on Aug 7, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	9 days
Due to Old age.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
Of autopsy None	

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 Harry L. McCarthy (M.D. or other) M.D.

Address Lewistown Mo. Date signed Aug 7

(Licensed Embalmer's Statement on Reverse Side)

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

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

Rev. 6-17-39 I X19511

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 myself

....., Registered Apprentice No.....,

working under my personal supervision.

Signed James A Coder

Licensed Embalmer No. 2532

P. O. Address Livestown 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, above space should be left blank.

S. No. 2B
1—2-21-40
I X22832

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28965

Registration District No. 479 Primary Registration District No. 36438 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Lewis
(b) ~~City or town~~ La Belle T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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 Mary McNalley
3. (b) If veteran, name war 1
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife, if alive
7. Birth date of deceased June 28 1862 (Month) (Day) (Year)
8. AGE: Years 78 Months 1 Days 9 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) Oct. 27-1948 (Date received local registrar) (b) P. W. Jennings (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7 year 1940 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.

Immediate cause of death — Duration
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 Harry McCracken M. D. (or other)
Address Lewistown Date signed

SUPPLEMENTARY