

No. 2  
13-40  
17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **30976**

**FILED SEP 26 1941**  
Registration District No. **72**

Primary Registration District No. **4041**

Registrar's No. **22**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
010

1. PLACE OF DEATH:  
(a) County **Boone**  
(b) City or town **CENTRALIA**  
(c) Name of hospital or institution: **So Jenkins Hl**  
(d) Length of stay: In hospital or institution **1**  
In this community **1** years, months or days

3. (a) PRINT FULL NAME **MARY ARTIE DANIELS**  
3. (b) If veteran, name war **NO**  
3. (c) Social Security No. **None**

4. Sex **F**  
5. Color or race **W**  
6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife **F. J. Daniels**  
6. (c) Age of husband or wife if alive years **31** months **12** days **1871**  
7. Birth date of deceased (Month) **MAR** (Day) **31** (Year) **1871**

8. AGE: Years **70** Months **4** Days **5**  
If less than one day hr. min.

9. Birthplace **Madison Co Mo. U**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business

12. Name **Squire Roberts**

13. Birthplace **Boone Co Mo. U**  
(City, town, or county) (State or foreign country)

14. Maiden name **L. Cantelero**

15. Birthplace **Boone Co Mo. U**  
(City, town, or county) (State or foreign country)

16. (a) Informant **P. H. Roberts**

(b) Address **Merury Mo**

17. (a) **Buried** (b) Date thereof **8/8/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Centralia Mo**

18. (a) Signature of funeral director **W. McChesney**

(b) Address **Centralia Mo**

19. (a) **8/8-1941** (b) **F. J. Borden**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Boone**  
(c) City or town **Centralia**  
(d) Street No. **So Jenkins Hl**  
(e) If foreign born, how long in U. S. A? **0** years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Aug** day **6** year **1941** hour **11** minute **20 P.M.**

21. I hereby certify that I attended the deceased from **8/6/41** to **8/6/41**, 19\_\_\_\_; that I last saw her alive on **8/6/41**, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions **Cystic fibrosis tumor**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **938**  
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? \_\_\_\_\_  
(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 **[Signature]** (M. D. or other) **D**  
Address **Centralia Mo** Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**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 \_\_\_\_\_

*M. J. [unclear]*

Licensed Embalmer No. \_\_\_\_\_

*2589*

P. O. Address \_\_\_\_\_

*Quetzalia, M.*

**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.**