

No. 2
5-18-40
-17-39
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FILED OCT 24 1941

State File No. _____

Registration District No. 952

Primary Registration District No. 5667

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Grove Springs Rural Franklin Twp
(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 Mo (b) County Laclede
(c) City or town Grove Springs Mo Rural Franklin Twp
(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 JONAH DANIEL

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Lucinda Daniel 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 8 1863
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Competition Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Isaac Daniel
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Daniels
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. C. Daniel
(b) Address Grovespring Mo.

17. (a) burial (b) Date thereof Aug 15 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation M. Bride Cemetery

18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon Mo.
19. (a) Sept 20 (b) Mrs. Vida Lambeth
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 13 year 1941 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 10 1941, to Aug 10 1941
that I last saw him alive on Aug 10 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Heart lesion
Valvular
Mitral insufficiency

Due to _____
Due to 9502

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

Major findings Of operations None
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 Dr. J. V. Hough (M. D. number) _____
Address Grovespring Mo. Date signed 8/15/41

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

MOTHER FATHER

RECEIVED
MAY 14 1964

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..... *W. E. Holman*

Licensed Embalmer No. *4107*

P. O. Address *Lebanon 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31880
Registrar's No.

Registration District No. 952

Primary Registration District No. 5617

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Grove Spring Rural
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jonah Daniel

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

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

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

7. Birth date of deceased Oct 8 1863
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day _____ hr. _____ min.)

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

10. Usual occupation _____

11. Industry of 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her 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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

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Burcham Co

Mad. Ord.

S-31880-1941