

Registration District No. 14

Primary Registration District No. 4028

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Barton  
(b) City or town Liberal  
(If outside city or town limits, write "RURAL", and name of township)  
(c) Name of hospital or institution:  
Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 12 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barton  
(c) City or town Liberal  
(If outside city or town limits, write "RURAL")  
(d) Street No. NONE  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

RACHEL ANN Mc LONE

3. (b) If veteran, name war NONE

3. (c) Social Security No. None

4. Sex Female

5. Color or race Wh.

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

6. (b) Name of husband or wife FRANK E. Mc LONE

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

7. Birth date of deceased: JAN (Month)

12 (Day) 1867 (Year)

8. AGE: Years Months Days If less than one day  
81 5 8 hr. min.

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

10. Usual occupation House wife

11. Industry or business Home

12. Name Orlando F. Smilie

13. Birthplace No Data (City, town, or county) PENN. (State or foreign country)

14. Maiden name Mahala Springer

15. Birthplace No Data (City, town, or county) Ill. (State or foreign country)

16. (a) Informant B. F. Smilie

(b) Address Mulberry, Kansas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-48 (Month) (Day) (Year)

(c) Place: burial or cremation Rosebank Cemetery

18. (c) Signature of funeral director Charles A. Dudley

(b) Address Mulberry, Kansas

19. (a) 6-21-48 (Date received local registrar) (b) Hortense Chastout (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 20 year 1948 hour 9 minute 05 A.M.

21. I hereby certify that I attended the deceased from 21 Jan. 3, 1946 to June 19, 1948 that I last saw her alive on June 19, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration 3 days

Due to Coronary Sclerosis

Other conditions Uremia and Dehydration Acidosis (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ 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? 2

23. Signature M. H. Kneeland (M. D. or other) D.O. While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
Address Liberal, Mo. Date signed June 25-48

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

823

X

1

25-48

RECEIVED

District Health Officer No. 6,

District File Number 748-805-

Date Filed JUL 15 1945

SEP 10 1951  
JUL 19 1948

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 J. Wilbur Koonce  
Licensed Embalmer No. 3935  
P. O. Address Pittsburg, Kansas

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1199  
15-1  
Registrar's No. \_\_\_\_\_

Registration District No. 14 Primary Registration District No. 4028

1. PLACE OF DEATH:  
(a) County Barton  
(b) City or town Liberal  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Rachel A. Malone  
3. (b) If veteran, name war \_\_\_\_\_ 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 2 years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 81 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) June 21, 48 (b) H. Malone (Registrar's signature)  
(Date received local registrar)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death cardiac failure

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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_ Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

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

5-22170