

K. 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.

SEP 13 1939

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

32911
Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 533
 (b) Township Hudson Primary Registration District No. 3027
 (c) City Macon (d) Street No. Macon, Mo. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Zeffie Magnus.

(a) Residence, No. Macon, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word) Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ott Magnus

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 28, 1886

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	52	9	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife..
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon County, Mo.

FATHER

13. NAME Monroe Brammer
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER

15. MAIDEN NAME Nellie Phipps
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Otto Magnus
 (ADDRESS) Macon, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Woodlawn Cem. DATE 9/10/39

19. FUNERAL DIRECTOR (NAME) Albert Skinner.
 (ADDRESS) Macon, Mo.

20. FILED 9/13 1939 Leola Neuhard
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 8, 1939

22. I HEREBY CERTIFY, That I attended deceased from
March 28 to Sept 8, 1939
 I last saw him alive on Aug 25, 1939 Death is said to have occurred on the date stated above, at 11:00 A. M.
 The principal cause of death and related causes of importance were as follows:
Cerebral apoplexy Aug 1938
Gen Arterio-sclerosis 1935+

Other contributory causes of importance:
Gen Arterio-sclerosis 1935+

Name of operation..... Date of.....
 What test confirmed diagnosis? clinical Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify.....
 (Signed) J. F. Turner, M. D.
 (Address) Macon, Mo.

RECEIVED

District Health Officer No. 10

District File Number 10-39-1733

Date Filed OCT 5 1939

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.....

.....
working under my personal supervision.

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

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.

Dr. Turner.