

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon

(c) Name of hospital or institution: Unknown  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 9  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

8. (a) PRINT FULL NAME Lizzie Scanlon 54<sup>5</sup>

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

4. Sex F 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept - 1855  
(Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days - If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation house keeper

11. Industry or business \_\_\_\_\_

12. Name Don't know

18. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Rosa Long

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lena Brooks

(b) Address Macon Mo

17. (a) burial (b) Date thereof May 20 '40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director Delbert Skuman

(b) Address Macon Mo

19. (a) 4/2/40 (b) Delbert Skuman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon

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

(d) Street No. 0  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 18  
year 1940 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct - 10, 1928, to Mar - 15, 1940; that I last saw her alive on Mar - 17, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 12-Mo

Due to (?)

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

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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? 476  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury ✓

23. Signature A L Combe (M. D. or other) M.D.  
Address Macon Mo Date signed Mar-30

PHYSICIAN

Underline the cause to which death should be charged statistically

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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 10

District File Number 4-40-723

Date Filed APR 9 1940

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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

*George H. Cole*

Licensed Embalmer No. 4066

P. O. Address Monroe, La.

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.