

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14187

State File No. \_\_\_\_\_

Registration District No. 12

Primary Registration District No. 5037

Registrar's No. 11

1. PLACE OF DEATH:

- (a) County Audrain  
(b) City or town Rural, South Wilson  
(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 years, months or days)  
In this community 50 years

3. (a) PRINT FULL NAME Mary Ellen Acton 235

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased November 16 1853  
(Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Winchester County, Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation None

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

12. Name Levi McCormack

13. Birthplace Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Emily J. Fox

15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. L. Acton

(b) Address R.F.D. #3, Centralia, Mo.

17. (a) Burial (b) Date thereof April 22, 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Unity, Audrain County

18. (a) Signature of funeral director Paul T. Pender

(b) Address Mexico, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Audrain  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.F.D. #3, Centralia, Mo.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20 year 1940 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from Nov. 39 to Apr. 20, 1940, that I last saw her alive on Apr. 5, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Carcinoma of breast

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

Due to 50

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

Major findings: Of operations \_\_\_\_\_

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

23. Signature Paul T. Pender (a) D. or other) \_\_\_\_\_  
Address Centralia, Mo. Date signed 4/24/40

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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.....

Earl E. Precht

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

working under my personal supervision.

Signed.....

*Earl E. Precht*

Licensed Embalmer No. 3189

P. O. Address Mexico, 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, above space should be left blank.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **14187**

Registration District No. **72**

Primary Registration District No. **5037**

Registrar's No. **11**

1. PLACE OF DEATH:

(a) County **Andrew**  
(b) City or town **South Wilson Sup**  
(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)

3. (a) PRINT FULL NAME

**Mary Ellen Acton**

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **and**  
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive. year

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

8. AGE: Years **86** Months **5** Days **4** If less than one day, h. 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) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address

19. (a) **3/5/40** (b) **F. H. Beeler** (Registrar's signature)

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) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month **Apr** day **20** year **1940** hour minute M.

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

Duration

Due to

Due to

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

Major findings: Of operations.

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 **G. M. Furner** (M. D. or other)

Address **Centralia** signed

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

SUPPLEMENTARY

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