

Registration District No. _____

Primary Registration District No. 5700

Registrar's No. _____

JUL 26 1940

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural - Lyda TP
(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 2
In this community 100 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon
(c) City or town Rural Lyda TP
(d) Street No. East of Atlanta
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Amy C. Wells 470

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

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

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

7. Birth date of deceased Feb 19 1838
(Month) (Day) (Year)

8. AGE: Years 102 Months 3 Days 26 If less than one day hr. _____ min. _____

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

10. Usual occupation House wife 1

11. Industry or business _____

12. Name William Batterson 1

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

14. Maiden name Eloza Gaines
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Elba Butler
(b) Address Atlanta, Mo.

17. (a) Burial (b) Date thereof 6-16-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mr. Jackson Cem
Stanton & Gooding

18. (a) Signature of funeral director Mason, Mo.
(b) Address _____

19. (a) June 18-40 Beth McNeely
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
year 1940 hour 5 minute 30 9 M.

21. I hereby certify that I attended the deceased from June 12 1940 to June 14 1940
that I last saw her alive on June 12 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure Duration ?

Due to Myocardial Regurgitation

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? 467
(Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature A Z Cambie (M. D. or other) MD
Address Atlanta Mo Date signed 6-18-40

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

RECEIVED

District Health Officer No. 10

District File Number 2-40-1319

Date Filed JUL 8 1940

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 _____

O. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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.