

No. 2  
-1-4-41  
-17-39  
X26390

DEPARTMENT OF THE COMMERCE  
BUREAU OF THE CENSUS  
FILLED OCT 16 1941  
940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

31963  
State File No.

Registration District No. Primary Registration District No. 2403 Registrar's No.

1. PLACE OF DEATH:

(a) County macon  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Jackson Township  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
(Specify whether  
In this community all her life  
years, months or days)

3. (a) PRINT FULL NAME Alice Steward

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Orla 6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased march 20 1891  
(Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 18 If less than one day hr. min.

9. Birthplace macon Ga  
(City, town, or county) (State or foreign country)

10. Usual occupation Home wife

11. Industry or business

12. Name David Garoahan  
13. Birthplace Penn.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Susan Morrison  
15. Birthplace N.C.  
(City, town, or county) (State or foreign country)

16. (a) Informant Orla Steward  
(b) Address Atlanta Ga

17. (a) Burial (b) Date thereof Aug 10 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt Auburn

18. (a) Signature of funeral director H. H. ...  
(b) Address Atlanta Ga

19. (a) 9-2-1941 (b) W. H. Hall  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County macon  
(c) City or town Atlanta Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.F.D. #1  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day 8th  
year 1941 hour 15 minute PM

21. I hereby certify that I attended the deceased from 1/10 1941 to 8/8 1941  
that I last saw h. e. r. alive on 8/26 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Embolus Duration 18 min  
Due to arteriosclerosis & hypertension 10 yrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None  
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?

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

23. Signature E. H. ... (M. D. or other) DO  
Address macon Ga Date signed Aug 24 1941

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

RECEIVED

District Health Officer No. 10

District File Number 10-41-1797

Date Filed OCT 8 1941

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

H M Goodding

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

H M Goodding

Licensed Embalmer No. 1750

P. O. Address

Atlanta, Ga.

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.

STANDARD CERTIFICATE OF DEATH

State File No. 31963

Registration District No. 970

Primary Registration District No. 5702

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Rural  
(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

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Alice Steward

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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Mar 20 1872  
(Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address \_\_\_\_\_

19. (a) Nov 8 1941 (b) Ruth Mcneely  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day \_\_\_\_\_ year 1941 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 \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

1941

S-31963