

FILED OCT 16 1941

Registration District No. 523

Primary Registration District No. 3027

Registrar's No. 69

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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

John McPherson

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

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

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

7. Birth date of deceased: Nov 2 1863
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 18
If less than one day _____ hr. _____ min.

9. Birthplace St Johns, Kan Brunswick N.S
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Merchant

11. Industry or business _____

12. Name Don't Know

13. Birthplace " " 9
(City, town, or county) (State or foreign country)

14. Maiden name " " _____
(City, town, or county) (State or foreign country)

15. Birthplace " " 9
(City, town, or county) (State or foreign country)

16. (a) Informant E. J. Jurgens

(b) Address Macon Mo

17. (a) removal (b) Date thereof Sept 21-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation San Francisco ca

18. (a) Signature of funeral director Albert Skinner

(b) Address Macon Mo

19. (a) 10/6/41 (b) John Jurner
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Calif (b) County San Francisco
(c) City or town San Francisco
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____
If yes, name country _____ (Yes or No) 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1941 hour 8:45 minute 0 M.

21. I hereby certify that I attended the deceased from Sept 14
to Sept 20 1941.

that I last saw him alive on Sept 19 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration 6 days

Due to _____
Due to _____

Other conditions Diabetes Generalized
(Include pregnancy within 4 months of death) arteriosclerosis

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 0

23. Signature J. J. Jurner (M. D. or other)
Address Macon Mo Date signed 9/20/41

4/1/41 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

MAR 31 1944

2.7
-1401

RECEIVED

District Health Officer No. 10

District File Number 10-41-1807

Date Filed OCJ 8 1944

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.....

Gus W. Dietrich

Registered Apprentice No. 295

working under my personal supervision.

Signed.....

Albert Skinner

Licensed Embalmer No. 75-1

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, fact should be so stated above.

Registration District No. 533

Primary Registration District No. 3027

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon

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

(d) Length of stay: In hospital or institution _____
(Specify whether In this community _____ years, months or days)

3. (a) PRINT FULL NAME John McPherson

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

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

(b) Name of husband or wife Edna McPherson 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Nov 2 1863
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 18 (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) 10/6/44 (b) Seeta H. Berdeh
(Date received from registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1944 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 _____

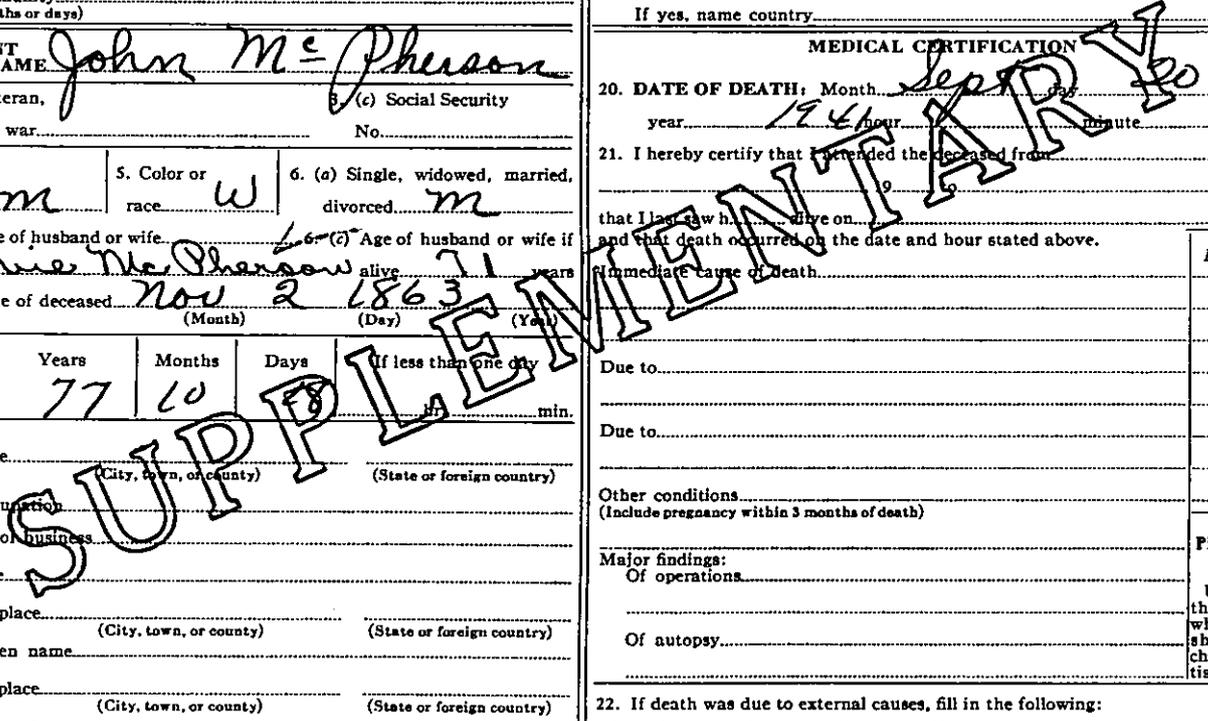
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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



MAR 31 1942

FEB 13 1942

1941
5-31976

NOV 27 1941