

Registration District No. 534

Primary Registration District No. 5718

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Rural N. Russel Township  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1  
(Specify whether)

In this community 68 years  
years, months or days)

3. (a) PRINT FULL NAME MARY GRACE MELDRUM

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Alexander Meldrum

6. (c) Age of husband or wife if alive 4 years (Day) (Year)

7. Birth date of deceased December 4 1873  
(Month) (Day) (Year)

8. AGE: Years 68 Months no Days no If less than one day hr. min.

9. Birthplace Macon Co. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name John P. Williams

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

14. Maiden name Grace Williams

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

16. (a) Informant Mrs. Ery Johnson

(b) Address St. Catherine Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 1941 (Month) (Day) (Year)

(c) Place: burial or cremation New Cambria Cemetery

18. (a) Signature of funeral director H. G. Hilleland

(b) Address New Cambria Mo.

19. (a) 12/4/41 (Date received local registrar) (b) Almena M. Hilleland (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Macon

(c) City or town Rural  
(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 Dec day 4 year 1941 hour 2 minute a.m.

21. I hereby certify that I attended the deceased from July 31 1940 to Dec 3rd 1941 that I last saw her alive on Dec 3rd 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Arterio Sclerotic Hypertension

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

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

Other conditions (Include pregnancy within 3 months of death) 596

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

Of autopsy no

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 [Signature] (M. D. or other) Address New Cambria Mo. Date signed Dec 4 1941

Duration 3 yr

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

61  
00

RECEIVED

District Health Officer No. 10

District File Number 1-42-43

Date Filed JAN 9 1942

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 \_\_\_\_\_

Licensed Embalmer No. 4019

P. O. Address New Cambria

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.