Form No. 2
4-51
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 1 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21722

Registration District No. 533 Primary Registration District No. 5720 Registrar's No. 61

1. PLACE OF DEATH:
(a) County: Macon
(b) City or town: Harrons Twp (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 .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Macon 61
(c) City or town: Harrons Twp 0 (If outside city or town limits, write "RURAL")
(d) Street No. ..... 0 (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Sarah Rooks
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: Widowed
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Oct 16 (Month) 185 (Day) 6 (Year)

8. AGE: Years 85 Months 8 Days 8 If less than one day ..... hr. ..... min.

9. Birthplace: Macon Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation: House Keeper
11. Industry or business .....
MOTHER FATHER
12. Name: James Ellis
13. Birthplace: (City, town, or county) Ky (State or foreign country)
14. Maiden name: Susan Brock
15. Birthplace: Macon Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Mrs Minnie Scott
(b) Address: R R Macon
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 26 (Month) 42 (Day) (Year)
(c) Place: burial or cremation: Friendship Cem
18. (a) Signature of funeral director: Albert Skinner
(b) Address: Macon Mo
19. (a) 7/2/42 (Date received local registrar) (b) Ora B. Hunckler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1942 hour 7:45 minute P M.
21. I hereby certify that I attended the deceased from Mar 20, 1942, to June 24, 1942, that I last saw her alive on June 19, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia	7 days
Due to: Fracture of Hip	3 mo
Due to: Falling	
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) 061 (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature: W. A. Davis (M. D. or other)
Address: Macon Mo Date signed 6/30/42

1637 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 7-42-1444
Date Filed JUL 16 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 Aelent S. Kimmer

Licensed Embalmer No. 751

P. O. Address Macon Ga

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21722

Registration District No. 533 Primary Registration District No. 5720 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 years, months or days)
In this community

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 Sarah Rowke
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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 16 1856 (Month) (Day) (Year)
8. AGE: Years 85 Months 8 Days 8 (If less than one day) hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fracture of Hip	
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) Accidental fall
(b) Date of occurrence Mar 20-1942
(c) Where did injury occur? home, Macon, co. Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home on farm house (Specify type of place)
While at work? No (e) Means of injury fall
23. Signature W. A. Davis (M.D. or other)
Address 1244 Vine st Macon Mo Date signed Aug 18/42

SUPPLEMENTARY
1860