

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED JUL 17 1942
Registration District No. 533

Primary Registration District No. 5720

State File No.
Registrar's No. 61

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Narrows Twp
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon
(c) City or town Narrows Twp
(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 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 2 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 1856
(Month) (Day) (Year)

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

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

10. Usual occupation House keeper

11. Industry or business

12. Name James Ellis
13. Birthplace Ky
(City, town, or county) (State or foreign country)
14. Maiden name Susan Brock
15. Birthplace Macon Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Minnie Scott
(b) Address R.R. Macon

17. (a) burial (b) Date thereof June 26 - 42
(Burial, cremation, or removal) (Month) (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 (b) Gra B. Hunkler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24
year 1942 hour 7:45 minute 7 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 Hypostatic Pneumonia Duration 7 days

Due to Fracture of Hip 3 mo

Due to Galling

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?.....

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

23. Signature W. A. Davis (M. D. or other).....
Address Macon Mo Date signed 6/20/42

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

MOTHER FATHER

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.....

Albert Steiner

Licensed Embalmer No.....

75-1

P. O. Address.....

Macon, 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.

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: Macon
 (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)

3. (a) PRINT FULL NAME Sarah Rooks
 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 _____ 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) _____ (b) _____
 (Date received local 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 June Day 24
 year 1942 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Structure of Hip
 Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.
1860
18

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
 While at work? no (Specify type of place)
 (e) Means of injury fall
 23. Signature W.A. Davis (M.D. or other)
 Address 124 1/2 Vine st Macon Mo. Date signed Aug 18 1942

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

SUPPLEMENTARY

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry should be supported by a valid receipt or invoice. This ensures transparency and allows for easy verification of the data.

In the second section, the author details the various methods used to collect and analyze the data. This includes both manual and automated processes. The goal is to ensure that the data is as accurate and reliable as possible.

The third section provides a detailed breakdown of the results. It shows that there is a significant correlation between the variables being studied. This finding is supported by statistical analysis and is consistent with previous research in the field.

Finally, the document concludes with a series of recommendations for future research. It suggests that further studies should be conducted to explore the underlying mechanisms of the observed effects. This will help to build a more comprehensive understanding of the phenomenon being investigated.