

FILED SEP 11 1942

Registration District No. 200

Primary Registration District No. 3041

Registrar's No.

1. PLACE OF DEATH: *Macon*

(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.....
In this community *all his life* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... *Missouri* (b) County..... *Macon*

(c) City or town..... *Macon*
(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..... *0*

3. (a) PRINT FULL NAME *Simon Ellen Singich*

3. (b) If veteran, name war..... *✓*

3. (c) Social Security No..... *✓*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* day *10*
year *1942* hour *8 A.M.* minute..... M.

4. Sex *Female* 5. Color or race *W*

6. (a) Single, widowed, married, divorced *2*

6. (b) Name of husband or wife..... *Simon Singich*

6. (c) Age of husband or wife if alive *no* years

7. Birth date of deceased..... *Oct-5-1870*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from.....
that I last saw him..... alive on *Dead when called*.....
and that death occurred on the date and hour stated above.

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

71 7 5 hr..... min.

Immediate cause of death *Chronic endocarditis*

Due to *Nephritis* ✓

9. Birthplace..... *Mo O*
(City, town, or county) (State or foreign country)

10. Usual occupation..... *Nurse wife*

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

MOTHER FATHER

11. Industry or business..... *✓*

12. Name..... *John Prange*

13. Birthplace..... *Mo O*
(City, town, or county) (State or foreign country)

14. Maiden name..... *Dora Prange*

15. Birthplace..... *Mo O*
(City, town, or county) (State or foreign country)

Of autopsy.....

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

16. (a) Informant..... *Simon Singich*

(b) Address..... *Macon*

17. (a) *Burial* (b) Date thereof *5/13/42*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... *Macon*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)..... *✓*

(b) Date of occurrence..... *5/10/42*

(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?.....

18. (a) Signature of funeral director..... *E. W. Nipper*

(b) Address..... *Macon*

19. (a) *8/22/42* (b) *John B. Hunchler*
(Date received local registrar) (Registrar's signature)

While at work (Specify type of place) Means of injury..... *2*

23. Signature..... *Dr. G. O. Edwards* (M. D. or other)
Address *123 1/2 Vine* Date signed *5/11/42*

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

RECEIVED

District Health Officer No. 10

District File Number 9-42-1714

Date Filed SEP - 8 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.....

P. O. Address.....

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. 27634

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Macou
 (b) City or town Macou
(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 Annie Ellen Linggich
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 10
 year 1942 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____;
 that I last saw him _____ live on _____ 19____;
 and that death occurred on the date and hour stated above.

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 _____
(Month) (Day) (Year)

Immediate cause of death Chronic Endocarditis
 Due to nephritis Chronic
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

8. AGE: Years _____ Months _____ Days _____
If less than one day
 9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____
 11. Industry or 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)

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

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)

23. Signature Dr. C. S. Edwards (M. D. or other) _____
 Address Macou mo. Date signed 8/29/42

SUPPLEMENTARY

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

MOTHER FATHER

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

