

S. No. 2
4-1-441
5-17-39
PI 231190
1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9751**

APR 15 1943
Registration District No. **43**

Primary Registration District No. **5135**

Registrar's No. **93**

1. PLACE OF DEATH:

(a) County **Butler**
(b) City or town **Fisk**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
PH #1 Fisk
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **6 mo.** years, months or days

3. (a) PRINT FULL NAME **Donald Ray Macom**

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

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

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

7. Birth date of deceased **Sept. 18, 1942**
(Month) (Day) (Year)

8. AGE: Years **6** Months **4** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name **Clarence Macom**

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

14. Maiden name **Ransy Coleman**

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

16. (a) Informant **Clarence Macom**

(b) Address **R-1, Fisk Mo. 123**

17. (a) **Burial** (b) Date thereof **3-27-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hillard Mo.**

18. (a) Signature of funeral director **Black's Mortuary**

(b) Address **Berning Dr.**

19. (a) **3-23-43** (b) **Belle Kierne**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Butler**
(c) City or town **Fisk**
(If outside city or town limits, write "RURAL")
(d) Street No. **PH #1**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **27**
year **1943** hour **2:05** minute _____ P.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.

Immediate cause of death: **Hydrocephalus at birth**
No doctor in attendance
Father advised Dr. Harwell of this city that child had enlarged head from birth

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

Duration
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 **Belle Kierne** (M. D. or other)
Address **Caplan Bluff Mo.** Date signed **3/23**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

12
0
0

RECEIVED

District Health Office No. 2

District File Number 443-450

Date Filed 4-12-48

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.