Dr H Bussinger

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25457

FILED AUG 6 1943

Registration District No. 200 — Primary Registration District No. 3041 — Registrar's No. 23

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

1. PLACE OF DEATH:
(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 ..... (Specify whether
In this community always
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 61
(a) State Mo (b) County Macon 2
(c) City or town 2
(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 ..... g

3. (a) PRINT FULL NAME Mary Atterbury
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 June (Month) 25 (Day) 1862 (Year)

8. AGE: Years 80 | Months 10 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Atlanta (City, town, or county) Mo O (State or foreign country)
10. Usual occupation House keeper
11. Industry or business .....
12. FATHER Name James Farmer
13. Birthplace Mo O (City, town, or county) (State or foreign country)
14. MOTHER Maiden name Margaret Armstrong
15. Birthplace Mo O (City, town, or county) (State or foreign country)
16. (a) Informant Shirley Eugene
(b) Address Macon
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25-43 (Month) (Day) (Year)
(c) Place: burial or cremation Bethel Cem
18. (a) Signature of funeral director Allen Skeen
(b) Address Macon Mo
19. (a) 6/8/43 (Date received local registrar) (b) Flora B. Hunkler (Registrar's signature)

1037

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22
year 1943 hour 6:25 minute P M.

21. I hereby certify that I attended the deceased from May 16, 1943, to May 22, 1943
that I last saw her ER alive on May 22 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bilateral bronchial pneumonia	3 days.
Due to: senility	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 107	

Major findings:
Of operations None
Of autopsy None.

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

23. Signature E L Hensinger (M. D. or other) MD
Address Macon Date signed 5-27-43

RECEIVED
District Health Officer No. 10
District File Number 8-43-1583 1247
Date Filed AUG 5 1943

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 S Kunnan

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 com... the above constitutes grounds for revocation of license.)

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

Vc. 2B
1—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. MG 5

Registration District No. 20 Primary Registration District No. 3041 Registrar's No. 53

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

1. PLACE OF DEATH:

(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:

(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 Mo (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

3. (a) PRINT FULL NAME Mary Atterbury

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 June (Month) 25 (Day) 1856 (Year)

8. AGE: Years 86 Months 10 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name

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

MOTHER
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) Iova B. Hunckler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 22 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , 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	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-28457