

FILED JAN 15 1944

Registration District No. 43

Primary Registration District No. 5027

1. PLACE OF DEATH

(a) County Harrison
(b) City or town Rural, Richardson 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: 21 da. (Specify whether years, months or days)

3. (a) PRINT FULL NAME MELISSA MACKAY

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

(b) Name of husband or wife Jas. A. Mackay 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased: 2 26 1862
(Month) (Day) (Year)

8. AGE: Years 81 Months 10 Days 2 If less than one day hr. min.

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

10. Usual occupation Homemaker

11. Industry or business

12. Name Joe Beason

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

14. Maiden name

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

16. (a) Informant William Beason

(b) Address Hamburg Iowa

17. (a) Removal (b) Date thereof 1-2-1944
(Special, common, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Olive Cem.

18. (a) Signature of funeral director Wm. Bartholomew

(b) Address Rock Park Mo.

19. (a) Jan. 1 1944 (b) Wm. Herbert Beason
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Fremont
(c) City or town Hamburg
(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 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 - 43
year 11 hour 30 minute M.

21. I hereby certify that I attended the deceased from for several
years, 19 to 1943
that I last saw her alive on Dec. 29, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death:

Pneumonia

Due to Myocarditis

Due to Embolic

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 A. G. Womack (M. D. or other)
Address Hamburg Iowa Date signed 12-30-43

1164

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

42
43
7:39
X35697

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

Leah Baruch Lerner

.....
Licensed Embalmer No.....

3173

P. O. Address.....

Rock Port, Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*

Jan.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Atchison
- (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

Melissa Mackey

- 3. (b) If veteran, name war _____

- 3. (c) Social Security No. _____

- 4. Sex 7

- 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 Feb 26 1960

(Month)

(Day)

(Year)

8. AGE:

Years 81

Months 10

Days _____

(Less than one day)

min. _____

- 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)

- 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)

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 Dec 1943 year 1943 Day _____ 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 _____

Thrombosis myocardialis

Due to Myocardium

Due to Coronary

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) (c) Means of injury _____

- 23. Signature W. W. Vanamaster (M. D. or other) _____
Address Hamburg, La. Date signed 1/15/44

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

SUPPLEMENTAL

108

S-4/461