

S. No. 2
M-5-43
7-5-17-39
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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. **11478**
Registrar's No. **30**

FILED APR 12 1944
Registration District No. **200**

Primary Registration District No. **5725**

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

1. PLACE OF DEATH:
(a) County **Macon**
(b) City or town **rural Hudson**
(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 **yes.** years, months or days _____

3. (a) PRINT FULL NAME **Mary E Via**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **2** **widow**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec. 25 1857**
(Month) (Day) (Year)

8. AGE: Years **86** Months **2** Days **16** If less than one day _____ hr. _____ min.

9. Birthplace **Holland** 4
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **Haryey Holdbrook**
13. Birthplace **Holland** 4
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah** **W.**
15. Birthplace **Burial Holland** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Walter Horvath**
(b) Address **Macon, Mo. R3**

17. (a) **Burial** (b) Date thereof **3-14-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Woodville, Mo.**

18. (a) Signature of funeral director **Stephen J. Gaddy**
(b) Address **Macon, Mo.**
19. (a) **3/29/44** (b) **J. P. A. Dunkler**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Macon** 61
(c) City or town **rural** 0
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **12**
year **1944** hour **4** minute **15** 9.M.
21. I hereby certify that I attended the deceased from **March 10th**
1944 to **March 12, 1944**
that I last saw her alive on **March 12, 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** 4 days
Secondary weakness of
advised eye of patient.
Due to _____
Due to _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy **108**
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)
(b) Means of injury _____
22. Signature **Dr. Lloyd Carroll** (M. D. or other) **D.O.**
Address **Macon, Mo.** Date signed **3/14/44**

RECEIVED

District Health Officer No. 10

District File Number 4-44-727

Date Filed APR 8 1944

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. 3057

P. O. Address Macon, 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.