

No. 2  
DM-2-43  
5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

FILED JUL 12 1944

Primary Registration District No. 3041

W.H. Smith 21996

1. PLACE OF DEATH:  
 (a) County Macon  
 (b) City or town \_\_\_\_\_  
 (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) 1  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ 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 \_\_\_\_\_

3. (a) PRINT FULL NAME Susie Smith  
 (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month June, day 2, year 1944, hour 3 minute P M.  
 21. I hereby certify that I attended the deceased from June 2, 1944, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Dec 10 - 1884  
 (Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage  
 Duration  sudden

8. AGE: Years 59 Months 5 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Other conditions Arteriosclerosis  
 (Include pregnancy within 3 months of death)

10. Usual occupation House wife

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name John Richardson  
 13. Birthplace N. Carolina  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Belle Sumpter  
 15. Birthplace Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Frank Smith  
 (b) Address RR Macon

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? \_\_\_\_\_

17. (a) burial (b) Date thereof Jun 24-44  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation woodlawn

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

18. (a) Signature of funeral director Albert Stumpfe  
 (b) Address macon mo  
 19. (a) 7/3/44 (b) Wm B. Funkler  
 (Date received local registrar) (Registrar's Signature)

23. Signature Edward Miller (M. D. or other) \_\_\_\_\_  
 Address macon Date signed 7/5/44

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

203

1437

**RECEIVED**

District Health Officer No. 10.

District File Number 7-44-1286

Date Filed JUL 11 1944

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**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 Carlton Minor

Licensed Embalmer No. 3414

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.

Registration District No. 200

Primary Registration District No. 304

1. PLACE OF DEATH:

(a) County Macou Mason  
(b) City or town Mason  
(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 Susie Smith

3. (b) If veteran, name was \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced em

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

7. Birth date of deceased Dec 10 (Month) (Day) (Year)

8. AGE: Years 59 Months 5 Days \_\_\_\_\_ If 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

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

21996