

3. No. 2
M-2-43
-17-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34705

State File No. _____

10/4
FILED NOV 14 1944
200

Primary Registration District No. 2725

Registrar's No. 104

1. PLACE OF DEATH:

(a) County MACON

(b) City or town MACON, MISSOURI
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Still-Hildreth Osteopathic Sch. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Jan. 18 - 43 to
(Specify whether years, months or days)

In this community Sept. 13, 1944

2. USUAL RESIDENCE OF DECEASED:

(a) State Louisiana (b) County Louisiana ⁹⁹⁹

(c) City or town Morning Star ¹³
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME Mrs. Evald. Huston

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13
year 1944 hour 2 minute 25 A. M.

21. I hereby certify that I attended the deceased from Sept. 5,
1944 to Sept. 13, 1944
that I last saw h. er. alive on Sept. 13, 1944
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 Widowed

6. (b) Name of husband or wife _____

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

Immediate cause of death Cerebral
arteriosclerosis with
Chronic Myocarditis ^{7yrs.}

Due to _____

Due to _____

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

930

7. Birth date of deceased: Aug 7 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 6
If less than one day hr. _____ min. _____

Major findings:
Of operations _____

Of autopsy _____

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

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name Humphrey Trumble

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

14. Maiden name Aurelia Vaughn

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

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? _____

16. (a) Informant C. R. Pierce

(b) Address Morning Star, Louisiana

17. (a) removal (b) Date thereof Sept 13 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem

18. (a) Signature of funeral director Robert Skiffner

(b) Address MACON, MISSOURI

19. (a) 11/3/44 (b) Yora B. Junker
(Date received local registrar) (Registrar's signature)

23. Signature Philip B. Leudagast (Specify type of place) (e) Means of injury 2

Address MACON, MO. (City or town) Date signed 9/13/44

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

RECEIVED

District Health Officer No. 10

District File Number 11-44-1883

Date Filed NOV 10 1948

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 Skinner

Licensed Embalmer No.

75-1

P. O. Address

Mason

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. None

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Macon Hudson

(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 _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Eval Huston

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 Aug 7 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Jona B. Lunkler

(b) Address _____

19. (a) _____ (b) Jona B. Lunkler
(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")

(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 Sept day 13
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 _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

34705