No. 2
8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1945

Registration District No. 200

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6572

Primary Registration District No. 5723

Registrar's No. 24

1. PLACE OF DEATH

(a) County Macon
(b) City or town College Mound rural (Chariton)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Sup
(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 Excello rural 61 Mo
(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 Frank M. Andrews
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M.
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lina Andrews
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased April (Month) 27" (Day) 1866 (Year)

8. AGE: Years 78 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Schuyler Co. Mo (City, town, or county) (State or foreign country)
10. Usual occupation Retired
11. Industry or business

MOTHER FATHER
12. Name Delong Powell Andrews
13. Birthplace Ky (City, town, or county) (State or foreign country)
14. Maiden name Martha J. Hughes
15. Birthplace Ky (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lina Andrews
(b) Address Excello, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Salem Macon Mo
18. (a) Signature of funeral director Stephens & Goddard
(b) Address Macon Mo
19. (a) 3/4/45 (Date received local registrar) (b) Tora B. Hunkler (Registrar's signature)

1037

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9"
year 1945 hour 8 minute 10 A.M.
21. I hereby certify that I attended the deceased from Feb 6, 1945 to Feb 9, 1945
that I last saw him alive on Feb 8, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fracture of Left hip	3 days.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED	
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: V 561
(a) Accident, suicide, or homicide (specify) V
(b) Date of occurrence
(c) Where did injury occur? V (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 V

23. Signature Howard Andrews (M. D. or other)
Address Macon Mo Date signed 3/4/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 3-46-490
Date Filed MAR 8 1945

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 O. L. Stephens

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 the above constitutes grounds for revocation of license.)

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

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 200 Primary Registration District No. 5723 Registrar's No. 24

1. PLACE OF DEATH:
(a) County Macon
(b) City or town College Mound Chariton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Dup
(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)

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

3. (a) PRINT FULL NAME Frank M. Andrews
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 27 1866
(Month) (Day) (Year)

8. AGE: Years 78 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 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)	
Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED	
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) accident
(b) Date of occurrence Feb 6 - 1945
(c) Where did injury occur? Excello A.T.D. Macon Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, public place?
About home (Specify type of place)
While at work? no (e) Means of injury Fall on ice

23. Signature H. Howard Duncan (M. D. or other)
Address Macon Mo Date signed

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