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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 10 1945
Registration District No. 200

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10154
Registrar's No. 27

Primary Registration District No. 3041

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

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Louise Linn
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: July 9 - 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____
12. Name James R. Burge
13. Birthplace Don't know
(City, town, or county) (State or foreign country)
14. Maiden name Mary Harris
15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Milton Roy
(b) Address Macon Mo

17. (a) burial (b) Date thereof Mar 3 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bloomington Cem

18. (a) Signature of funeral director Adm't. B. K. Jensen
(b) Address Macon Mo
19. (a) 3/6/45 (b) Jara B. Dunkle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (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? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 1
year 1945 hour 10 minute a.m.

21. I hereby certify that I attended the deceased from July 20, 1944 to March 1, 1945; that I last saw her alive on March 1, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration 1 week

Due to Chronic Passive Congestion of the Lungs
Due to Coronary Artery Disease of the Heart 1 month

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

Major findings: Of operations _____ Of autopsy H&E

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 W. P. L. Milledge (D. or other) _____
Address Macon, Mo Date signed 3/3/45

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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 Albert S. Kummer
Licensed Embalmer No. 75-1
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.