

No. 2  
8-43  
5-17-39  
K37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24448**

**FILED** JUN 26 1945  
Registration District No. **JR 06**

Primary Registration District No. **51725**

Registrar's No. **74**

1. PLACE OF DEATH:

(a) County macon

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

(c) Name of hospital or institution: Still-Hildreth 6  
(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 14 years

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Lena Reed Mansfield

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 widow

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

7. Birth date of deceased Feb 26 1870  
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William A Reed

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

14. Maiden name Elizabeth Winter

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

16. (a) Informant Walter W. Hurrett

(b) Address Jefferson City Mo

17. (a) Burial (b) Date thereof 5-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina Mo

18. (a) Signature of funeral director Estayes

(b) Address Shelbina

19. (a) 7/3/45 (b) Jara B. Hunkler  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 22  
year 1945 hour 9 minute 00 P.M.

21. I hereby certify that I attended the deceased from Sept. 6 1944 to June 22 1945  
that I last saw her alive on June 22 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Senile Dementia  
Duration \_\_\_\_\_

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

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

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

Major findings: Of operations 1632

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:

(c) 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 Anna L. Mance (D. O. other) \_\_\_\_\_  
Address macon mo Date signed 6/23-45

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

1057

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 7-45-1102

Date Filed JUL 13 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

*E. Hayer*

Licensed Embalmer No. 1437

P. O. Address \_\_\_\_\_

**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. Aug  
Registrar's No. 748

Registration District No. 200 Primary Registration District No. 0725

1. PLACE OF DEATH:  
(a) County Macoupin  
(b) City or town Rural Marion  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

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 Lena R. Mansfield  
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 wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb - 26 (Month) (Day) (Year)

8. AGE: Years 75 Months 3 Day 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 7/19/45 (b) Lena B. Dunkle  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

SUPPLEMENTARY 2

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

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

S-24448