

No. 2  
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5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30953**

**FILED** SEP 28 1945

Registration District No. **208**

Primary Registration District No. **5725**

Registrar's No. **92**

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

**1. PLACE OF DEATH:**

(a) County Macon

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

(c) Name of hospital or institution: Hudson Hosp

(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 Mo (b) County Macon

(c) City or town Rural (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 Mo

**3. (a) PRINT FULL NAME** Ella McNameara

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

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Aug day 21 year 1945 hour 9 minute P M.

**21. I hereby certify that I attended the deceased from** Aug 4 1945 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 Single

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

7. Birth date of deceased: Feb 21 1867  
(Month) (Day) (Year)

that I last saw h. w alive on Aug 21 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardio-vascular disease Duration 30 mm years

**8. AGE:** Years 78 Months 6 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

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

10. Usual occupation House Keeper

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 Michael McNameara

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

14. Maiden name Mary Behan

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

16. (a) Informant Pat McNameara

(b) Address Macon Mo

17. (a) Rural (b) Date thereof Aug 24 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thomas Cem

**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? \_\_\_\_\_

18. (a) Signature of funeral director Thomas Skuerr

(b) Address Macon Mo

19. (a) 7/4/45 (b) Dora B. Funkler  
(Date received local registrar) (Registrar's signature)

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

23. Signature J.P. Cronan M.D. (Other) \_\_\_\_\_

Address Macon Mo Date signed 8/29/45

1037

RECEIVED

District Health Officer No. 10

District File Number 9-45-1436

Date Filed SEP 17 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 Albert S. Kumar

Licensed Embalmer No. 751

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.**