

No. 2
8-43
7-39
X37823

FILED JAN 30 1946

Registration District No.

Primary Registration District No. 57-25

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Macon
(b) Rural Macon Harrison Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Still - Hilduth Osteopathic San. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community 6 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Louis 999
(c) City or town Morning Sun 13
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18
year 1945 hour 2 minute P.M.
21. I hereby certify that I attended the deceased from
Dec 12, 1945, to Dec 18, 1945;
that I last saw her alive on Dec 17, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Senile Dementia
Complicated by Chronic Myocarditis
Duration

Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 921
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature M. J. Trubuck (M., D., or other) DO
Address Still - Hilduth Oste. San. Date signed Dec 18 '45

3. (a) PRINT FULL NAME Fannie Adams
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 Widowed

6. (b) Name of husband or wife Harvey M. Adams 6. (c) Age of husband or wife if alive years

7. Birth date of deceased May 6 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name John Rogers Reasoner

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

14. Maiden name Amanda Melvina Miller

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

16. (a) Informant Mrs. Ethel Lewis
(b) Address 1810 Oakland Ave. St. Paul, Minn.

17. (a) Interment (b) Date thereof Dec. 21 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Morning Sun Cemetery
18. (a) Signature of funeral director Albert Skinner
(b) Address Macon Mo

19. (a) 1-6-46 (b) Juth McNeely
(Date received local registrar) (Registrar's signature)

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

100577

RECEIVED
District Health Officer No. 10
District File Number 1-46-230
Date Filed JAN-28-1946

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 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 19

Registration District No. 200

Primary Registration District No. 5725

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural Hudson
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Fannie Adams

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 _____

7. Birth date of deceased May (Month) 1 (Day) 1918 (Year)

8. AGE: Years 86 Months 7 Days _____ (less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb 4 46 (b) Deak Meneely
(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 Feb 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 _____

Duration _____

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

MOTHER FATHER

SUPPLEMENTARY

3250