

FILED APR 15 1946

Registration District No. **79**

Primary Registration District No. **5373**

Registrar's No. **28**

1. PLACE OF DEATH:

(a) County **DeKalb**
(b) City or town **Maysville (Rural)**
(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 _____ **60 yrs**
years, months or days

3. (a) **PRINCE**
FULL NAME **ARAH LIZABETH LINCOLN**

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~~ **X 21**

6. (b) Name of husband or wife **Albert Lincoln** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 25 - 1886**
(Month) (Day) (Year)

8. AGE: Years **89** Months **11** Days **0** If less than one day hr. _____ min. _____

9. Birthplace **Morrow Co, Ohio** 1
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

MOTHER FATHER

11. Industry or business _____

12. Name **Joseph Pierce** 1

13. Birthplace **Ohio** 1
(City, town, or county) (State or foreign country)

14. Maiden name **Agnes Conger**

15. Birthplace **Ohio** 1
(City, town, or county) (State or foreign country)

16. (a) Informant **North Lincoln**

(b) Address **Maysville Mo**

17. (a) **Burial** (b) Date thereof **3-27-46**
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Mt**

18. (a) Signature of informant **Joseph Pierce**

(b) Address **Maysville Mo**

19. (a) **3-26-46** (b) **Res. W. Dandrew**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **DeKalb**
(c) City or town **Maysville (Rural)**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) **0**

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **25**
year **1946** hour **10** minute **a** M.

21. I hereby certify that I attended the deceased from **March 20**, 19**46** to **March 22**, 19**46**
that I last saw her alive on **March 22**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of**
left maxillary gland - 10 yrs.
Bladder and Rectum 17 1/2.

Duration _____
Cause **Two lobes in left**
maxillary area were treated by
Dr. A. J. Smith at Mo. Methodist Hosp.
in 1936

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

Major findings:

Of operations _____
Of autopsy _____

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED**

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 **R. R. Reynolds, M.D.** (M.D. or other) **3/26**
Address **Maysville Mo** Date signed **3/26**

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

[Handwritten Signature]

Licensed Embalmer No. 3960

P. O. Address *Wayville 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. April
Registrar's No. 28

Registration District No. 99

Primary Registration District No. 5373

1. PLACE OF DEATH:

(a) County DeKalb
(b) City or town Rural
(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

Sarah E. Tricahn

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 Apr 25 (Month) (Day) (Year)

8. AGE: Years 89 Months _____ Days _____ (If less than one day) _____ hr. _____ min.

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

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) _____ (b) _____ (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 _____ Year 1946 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 Left inguinal glands

Due to _____

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

Major findings: Of operations _____

Of autopsy 552

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 R.R. Reynolds (M. D. or other) Dr.

Address Mayfield mo Date signed 4/23/46

SUPPLEMENTARY

MOTHER FATHER

7813

8944