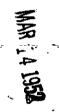
DEPARTMENT OF COMMERCE THE STATE BOARD OF BUREAU OF THE CENSUS 27 1946STANDARD CERTIF	HEALTH OF MISSOURI ICATE, OF DEATH State File No. 10054
Registration District No. 200 Primary Registration District	ict No. 3041 Registrar's No. 45
1. PLACE OF DEATH	2. USUAL RESIDENCE OF DECEASED:
(a) County Water	(a) Stat Mistorii (b) County macon
(If outside city or town limits, write "RURAL" and name of township)	(c) City or town Zuacon
(c) Name of hospital or institution:	(If outside city or town limits, write "RURAL")
(If not in hospital or institution, write street number or location)	(d) Street No
(d) Length of stay: In hospital or institution	(If rural, give location)
. (Specify whether	(e) Citizen of foreign country? (Yes or N
In this community years, months or days)	If yes, name country
	MEDICAL CERTIFICATION
3. (a) PRINT / homas adams	7.1
3. (b) If veteran, 3. (c) Social Security	20. DATE OF DEATH: Month 12 day
name war	year / 4 6 hour /, 30 minute 1
<u> </u>	21. I hereby certify that I attended the deceased from
55. Coloffor 6. (a) Single, widowed, married	1996 to 32, 199
4. Sex Mace racy 12970 divorced marrie	I that I last saw h 1 A alive on
6. (b) Name of husband or wife	and that death occurred on the date and hour stated above.
aliveyears	Immediate cause of death
7. Birth date of deceased (Month) (Day) (Year)	Cubral Timouhage,
(Month) (Day) (Telk)	
8. AGE: Years Months Days If less than one day	Due to
/6 9 /3 hr. min	1 Drumme V
0	Due to
9. Birthplace (Gity, town, or county) (State or foreign country)	
10. Usual occupation	Other conditions.
to. Usual occupation	Other conditions. (Include pregnancy within 3 months of death) Major findings: Of operations Underlied the cause
1: Industry or business	Major findings: Of operations Underlied Underlied Which dea
12. Name Frank adams	Ur operations
13. Birthplace 200	Of autopsy Showd of S
(State or foreign country)	Of autopsy should charged st
14. Maiden name 12 12 12 13 15. Birthplace (Sittle of Sealer annum)	tistically.
(City, town, or county) (State or foreign country)	22. If death was due to external causes, fill in the following:
6. (a) Informant 105.a 13. adams	(a) Accident, suicide, or homicide (specify)
(b) Adires macon mo	(b) Date of occurrence.
7. (a) bureal (b) Date thereof 724/46	(c) Where did injury occur?
(Burial, cremation, or removal) (Month) (Pay) (Year)	(City or town) (County) (State) (d) Did injury occur in or about home, on farm, in industrial place, in public place
(c) Place: burial or cremation Nocal aura Con	<u> </u>
8. (a) Signature of funeral director Octor S Kassen	While at work? (Specify type of place) (6) Means of injury.
(b) Address mag con wine	
, (1) 2/28/46 (1) Kuth M'neely	23. Signature M. D. or other



RECEIVED
District File Number 3-46-555

Deta Filed ___MAR-1-9-1946____

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	
Peristand Approprias No	
working under my personal supervision.	

Signed Ullest 5 Kanna 15-1

P.O. Address Macon nea

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.

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(b) Address.....

(Date received local registrar)

No. 2B

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State	File	No.	I po	w	1
				4	1-

Date signed.

·O

Primary Registration District No 3 8 4/ Registration District No. 200 Registrar's No. 2. USUAL RESIDENCE OF DECEASED: 1. PLACE OF DEATH: nacou ma (a) County..... (a) State......(b) County..... (If outside city or town limits, write "RURAL" and name of township) (c) City or town..... (c) Name of hospital or institution: (If outside city or town limits, write "RURAL") (d) Street No..... (If not in hospital or institution, write street number or location) (If rural, give location) (d) Length of stay: In hospital or institution..... (e) Citizen of foreign country?..... (Specify whether 🚛(Yes or No) In this community..... years, months or days) If yes, name country... MEDICAL CERTIFICS 3. (a) PRINT FULL NAME... 3. (c) Social Security 3. (b) If veteran. No..... 21. I hereby certify that I attended the dicease 5. Color or 6. (a) Single, widowed, married. death occurred on the date and hour stated above. 6. (c) Age of husband or wife if 6. (b) Name of husband or wife... Duration 7. Birth date of deceased. MC 8. AGE: 9. Birthplace... (State or foreign country) Other conditions.... 10. Usual occupation (Include pregnancy within 3 months of death) ADDITIONAL PHYSICIAN 11. Industry or their Major findings: SUPPLEMENTARY Of operations..... 12. Name..... IMPORMATION Underline the cause to 13. Birthplace...(City, town, or county) which death REQUESTRO should be Of autopsy..... charged sta-14. Maiden name. tistically. 15. Birthplace... 22. If death was due to external causes, fill in the following: (City, town, or county) (State or foreign country) (a) Accident, suicide, or homicide (specify).... 16. (c) Informant..... (b) Date of occurrence...... (c) Where did injury occur?..... 17. (a) _____ (b) Date thereof..... (City or town) (County) (Month) (Day) (Year) (d) Did injury occur in or about home, on farm, in industrial place, in public place? (Burial, cremation, or removal) (c) Place: burial or cremation Specify type of place) 18. (a) Signature of funeral director..... While at wor

Address

(Registrar s signature)

10054

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