

No. 2
1-5-43
5-17-39
I X36671

STANDARD CERTIFICATE OF DEATH

State File No. **15574**
Registrar's No. **142**

FILED JUN 14 1946

Registration District No. **1**

Primary Registration District No. **3000**

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

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Grim-Smith Hospital & Clinic**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 hours**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **John Andrew Macomber**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **July 19 1889**
(Month) (Day) (Year)

8. AGE: Years **56** Months **9** Days **23** If less than one day hr. min.

9. Birthplace **Queen City Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER

12. Name **Zebina Alonzo Macomber**

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

14. Maiden name **Julia Ann Funk**

15. Birthplace **Queen City, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Glen Macomber**

(b) Address **Queen City, Missouri**

17. (a) **Burial** (b) Date thereof **5/13-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Larr Cemetery**

18. (a) Signature of funeral director **Wm H Ober**

(b) Address **Queen City MO**

19. (a) **5-14-46** (b) **Not Lambert**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Schuyler 98**
(c) City or town **Queen City**
(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 **May** day **13**
year **1946** hour **6:P.M.** minute M.

21. I hereby certify that I attended the deceased from **May 13, 12:P.M. 1946 to May 13, 6:P.M. 1946**
that I last saw him alive on **May 13, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplexy (83a)** Duration **12 hours**

Due to

Due to

Other conditions **Diabetes mellitus**
(Include pregnancy within 3 months of death)
Cardio-vascular-Renal disease

Major findings: Of operations

Of autopsy **61**

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) (c) Means of injury

23. Signature **J. H. ...** (M. D. or other) **MD**

Address **Wickville, Mo.** Date signed **5/13/46**

RECEIVED

District Health Officer No. 10

District File Number 6-46-1207

Date Filed JUN 13 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 Self

....., Registered Apprentice No.

working under my personal supervision.

Signed Wm A West

Licensed Embalmer No. 2882

P. O. Address Green City 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.