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X36671

FILED MAY 27 1946
Registration District No. **200**

Primary Registration District No. **5723**

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

1. PLACE OF DEATH:

(a) County **MACON**

(b) City or town **Colley, Macon, rural, Chariton**
(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 _____ years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **MACON 61**

(c) City or town **rural 0**
(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 _____

3. (a) PRINT FULL NAME **Angie Lina Christianson**

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

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **single 0**

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

7. Birth date of deceased **August 26 1945**
(Month) (Day) (Year)

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

6 7 0 hr. min.

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

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **Alford B. Christianson**

13. Birthplace **Randolph Co., Mo., 0**
(City, town, or county) (State or foreign country)

14. Maiden name **Ethel J. Andrews**

15. Birthplace **Macon Co., Mo., 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Alford B. Christianson**

(b) Address **Excelsior, Mo., R. 2**

17. (a) **Burial** (b) Date thereof **3-10-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Woodlawn Cem**

18. (a) Signature of funeral director **Stephens & Gording**

(b) Address **Macon, Mo.**

19. (a) **4-13-46** (b) **Futh McNeely.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **8**
year **1946** hour **3** minute **40** A.M.

21. I hereby certify that I attended the deceased from **Oct**
_____ 19**45**, to **Mar 8** 19**46**
that I last saw her alive on **Mar 7** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration **2 days**

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

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)
(c) Means of injury **0**

23. Signature **Howard Mueller** (M. D. or other)
Address **Macon** Date signed **4/4/46**

185

RECEIVED
District Health Officer No. 10
District File Number: 5-46-1604
Date Filed: MAY-2-3-1946

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 partially

....., Registered Apprentice No.
working under my personal supervision.

Signed C. L. Stephens
.....
Licensed Embalmer No. 3057
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. June
Registrar's No. 54

Registration District No. 200

Primary Registration District No. 5723

1. PLACE OF DEATH:

(a) County Macou
(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 _____ (years, months or days)

3. (a) PRINT FULL NAME Angela Christiana

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 S

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

7. Birth date of deceased Aug 26 (Month) (Day) (Year)

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

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

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 Mar 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 _____

Due to _____ Duration 2 Days

Due to _____

Other conditions _____ (Include pregnancy within 3 months)

Major findings: _____

Of operations _____

Of autopsy _____

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 Howard Nichols (M. D. or other) _____

Address Macou Date signed 12/31/46

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

108

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

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