S. No. 2
M—5-43
r. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 10 1946

State File No. 27710

Registration District No. 206 Primary Registration District No. 3041 Registrar's No. 94

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon 61

(c) City or town Macon 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME Nat M. Lacy

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M. O

5. Color or race W

6. (a) Single, widowed, married, divorced M G L

6. (b) Name of husband or wife Daisy

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Aug. (Month) 6" (Day) 1874 (Year)

8. AGE: 71

Years	Months	Days	If less than one day
71	11	12	..... hr. ..... min.

9. Birthplace Nineveh (City, town, or county) Ind (State or foreign country) 1

10. Usual occupation Lawyer

11. Industry or business .....

FATHER
12. Name James D. Lacy 1
13. Birthplace Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Tanae Maris 1
15. Birthplace Ind (City, town, or county) (State or foreign country) 1

16. (a) Informant Mrs Nat M. Lacy
(b) Address Macon, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-46 (Month) (Day) (Year)
(c) Place: burial or cremation Franklin Ind

18. (a) Signature of funeral director Stephens & Goodding
(b) Address Macon, Mo

19. (a) 8/30/46 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July day 24th year 1946 hour 4 minute 50 p. M.

21. I hereby certify that I attended the deceased from Oct 19th 1945 to time of death 1946 that I last saw him alive on July 24th 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Angina Pectoris	5 min.
Due to Acute indigestion	
Due to Had 2 previous attacks this one the third one.	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

94B

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 3

23. Signature Dr Lloyd J. Carroll (M. D. or other) D.O.

Address Macon Mo Date signed 7/25/46

185

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-46-1643
Date Filed SEP 7 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 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.

2B
45
13880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE ...MANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 94

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon
(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)

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

3. (a) PRINT FULL NAME Nat M. Lacy

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Daisy Lacy

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Aug (Month) 6 (Day) 1874 (Year)

8. AGE: Years 71 Months 11 Days 12 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Sept 13/46 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Day 24
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h 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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

27710