

FILED SEP 12 1946

Registration District No. 199

Primary Registration District No. 5732

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural, Easley Township
(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 Missouri (b) County Macon
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. West of Fa Plata mo
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EDWARD, MAGERS

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 Married
6. (b) Name of husband or wife Era P Magers 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 66 Months 4 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name John B. Magers
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name Margaret Ruth
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant Era P Magers
(b) Address So. Cross mo

17. (a) Burial (b) Date thereof Aug 29 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Indian Hill
18. (a) Signature of funeral director Dr. H. H. Cullen
(b) Address South Siftard mo

19. (a) Sept. 1, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28 year 1946 hour 13 minute 10 A.M.
21. I hereby certify that I attended the deceased from 7/27/46 to 8/3/46
that I last saw him alive on 8/3/46 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary
Duration _____

Due to _____
Due to _____

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

Major findings: Of operations 136
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) MD
Address Franksville, Mo. Date signed 7/3/46

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 9-46-1733
Date Filed SEP 1 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 *J. H. W. Collins*
Licensed Embalmer No. 2052
P. O. Address *South Gifford Va.*

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.