

FILED OCT 17 1946 STANDARD CERTIFICATE OF DEATH

34137
State File No.

Registration District No. 700

Primary Registration District No. 5725

Registrar's No. 108

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Hudson Twp
(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 Mo (b) County Macon
(c) City or town Hudson Twp Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Jane Smith

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

4. Sex Female 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 26 - 1866 years
7. Birth date of deceased Dec 26 - 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Eph Nelson

13. Birthplace No Record
(City, town, or county) (State or foreign country)

14. Maiden name Mary G. Guathouse

15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Eus Ahlborn

(b) Address R R Macon Mo

17. (a) Rural (b) Date thereof 5/22-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT Oliv Cem

18. (a) Signature of funeral director Edw S Keener

(b) Address macon mo

19. (a) 10-1-46 (b) Juth McNeely
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1946 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from 27 1946 at 9-10 P. M.
that I last saw her alive on 9-10 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cardiac Failure Duration 4 Days
Due to Coronary sclerosis and infarction 2 mo
Due to Arterial sclerosis ?
Other conditions Chol. nephritis ?

Major findings: _____
Of operations

Of autopsy 131B

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? No

While at work? (Specify type of place) _____

Means of injury _____

23. Signature H P Orr (M. D. or other) _____

Address macon mo Date signed 9-23-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1815

RECEIVED
District Health Officer No. 10
District No. 46-1856
OCT 14 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... *Albert Skinner*
Licensed Embalmer No. *75-1*
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.