

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

1. PLACE OF DEATH:

(a) County Macon
 (b) City or town Callao
(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 Monroe
 (c) City or town Santa Fe Mo
(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 ADA B. WILKERSON
 3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 7
 year 1947 hour 10 minutes 30 A. M.

4. Sex Female 5. Color or race wh. 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from September, 1946 to January, 1947
 that I last saw h. or alive on January 6, 1947
 and that death occurred on the date and hour stated above.

7. Birth date of deceased: 8 - 7 - 1859
(Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 0 If less than one day _____ hr. _____ min.

Immediate cause of death Mycobacterium
 Due to Senile Debility
Septicemia
 Due to gangrenous septum

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

10. Usual occupation domestic

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations 9/3/46
 Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name ZACK B. HUNT
 13. Birthplace Mo
(City, town, or county) (State or foreign country)
 14. Maiden name Cox
 15. Birthplace Mo
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. F. W. Magraw
 (b) Address Callao Mo
 17. (a) Burial (b) Date thereof 1-8-47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Santa Fe Mo
 18. (a) Signature of funeral director W. F. Allen
 (b) Address Callao Mo
 19. (a) Jan 8, 1947 (b) W. F. Allen
(Date received local registrar) (Registrar's signature)

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 R. S. Meade (M.D. or other) 2
 Address Macon, Mo Date signed 1/8/47

APR 30 1947

FEB 25 1950

1961 FEB 7 1947

RECEIVED
Director of Health Officer No. 1
JAN 16 1947

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. G. Edwards*

Licensed Embalmer No. 1961

P. O. Address Revis, 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.