

S. No. 2
1-12-45
5-17-39
X47070

FILED MAR 26 1947

Registration District No. _____ Primary Registration District No. **3041**

1. PLACE OF DEATH
(a) County **Macon**
(b) City or town **Macon, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Samaritan Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **4 days**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Macon**
(c) City or town **Macon Co., 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 **Laura Pearl Maody**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Female** 5. Color or race **W** 6. (c) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 15 - 1877**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb.** day **20** year **1947** hour **9** minute **49 P.M.**
21. I hereby certify that I attended the deceased from **12-19-46** to **2-19-47**
that I last saw h. **or** alive on **2-19-47** and that death occurred on the date and hour stated above.

8. AGE: Years **69** Months **6** Days **5** If less than one day _____ hr. _____ min.
9. Birthplace **Clark Co., Mo.** (City, town, or county) (State or foreign country) **0**

Immediate cause of death **Cerebral Apoplexy** Duration **3 days**
Retrosclerosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business
12. Name **John R. Stamper** 9
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **Mary Elizabeth Welke**
15. Birthplace _____ (City, town, or county) (State or foreign country)
16. (a) Informant **Mr. Robert Baker** 13
(b) Address **St. Louis, Mo.**
17. (a) **Burial** (Burial, cremation, or removal) Date thereof **2-23-1947**
(b) Place: burial or cremation **Mr. Baker Co. Stephens & Goodday**
18. (a) Signature of funeral director **Macon, Mo.**
(b) Address _____
19. (a) **2-17-47** (Date received local registrar) (b) **Ruth Mcneely** (Registrar's signature)

PHYSICIAN
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) (b) Means of injury _____
23. Signature **A. L. Shuck** (M.D. or D.O.)
Address **macon** Date signed **3/11/47**

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

RECEIVED
District Health Officer No. 10
District File Number 3-47-5829
Date Filed - MAR-25-1947

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..... *R. 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.