DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 17 1947

Registration District No. 200

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14130

Primary Registration District No. 3041

Registrar's No. 173

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 years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Macon 61

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

(d) Street No. 2 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Ella Lamb

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 ..... years

7. Birth date of deceased: June 16 1861 (Month) (Day) (Year)

8. AGE: Years 86 | Months 2 | Days 22 | If less than one day ..... hr. ..... min.

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

10. Usual occupation: Housewife

11. Industry or business .....

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

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

16. (a) Informant: Mrs Elsie Swan
(b) Address: Macon Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar 27-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Chapel Hill Cem

18. (a) Signature of funeral director: Albert Skinner
(b) Address: Macon Mo

19. (a) 4/7/47 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 24 year 1947 hour 1:30 minute a M.

21. I hereby certify that I attended the deceased from Dec 1945 to Mar 24 1947 that I last saw her alive on Mar 22 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar Pneumonia	
Due to: Hip Fracture	
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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following: 61

(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: Dr C. D. Edwards (M. D. or other) M.D.

Address: Macon, Mo Date signed: 3/28/47

145 — (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer N
District File Number 4-4
Date Filed APR 15 19

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

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14130

Registration District No. 200 Primary Registration District No. 5725 Registrar's No. ~~147~~ 173

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County

(b) City or town (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 Ella Lamb.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

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

9. Birthplace North Troy (City, town, or county) V.T. (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year 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 Labor Pneumonia

Due to Hip Fracture

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Oct. 3 1945

(c) Where did injury occur? Macon (City or town) Macon (County) Mo (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury

23. Signature Dr. C. D. Edwards (M. D. or other) DO

Address Macon, Mo. Date signed 6/1/45

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

14130