

FILED JUN 4 1947

Registration District No. 201

Primary Registration District No. 4315

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Ladelle
(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 37 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61
(c) City or town Ladelle 2
(If outside city or town limits, write "RURAL") 6
(d) Street No. 1 (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 1

3. (a) PRINT FULL NAME Margaret Elizabeth McKenzie
(b) If veteran, name war 1 (c) Social Security No. 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29, year 1947 hour 1 minute 0 A. M.

21. I hereby certify that I attended the deceased from May 10, 1947 to May 29, 1947 that I last saw her alive on May 26, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Duration short

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife 1 6. (c) Age of husband or wife if alive 6 years (Day) (Year)

7. Birth date of deceased Sept 6 - 1867
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 23 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business

12. Name William Cierec 13. Birthplace Ohio (City, town, or county) (State or foreign country)

14. Maiden name Steph Cierec 15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant J. Frank McKenzie (b) Address Ladelle Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31 - 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Green City

18. (a) Signature of funeral director D. S. Christie (b) Address Ladelle Mo

19. (a) May 31 - 47 (Date received local registrar) (b) Ms. O. A. Suffer (Registrar's signature) 186

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 85

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 0

23. Signature O. A. Suffer (M. D. or D. V. M.)
Address Ladelle Mo Date signed 5-29-47

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 6-47-937
Date Filed JUN - 3 1941

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 D. S. Christie
Licensed Embalmer No. 1109
P. O. Address For Plata 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.