

No. 2
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-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 13 1948
200

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18305**
Registrar's No. **308**

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

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: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County Macon
(c) City or town Macon
(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 Josie B. McAfee
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 Married
6. (b) Name of husband or wife W. B. McAfee
6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased Dec. 28 187
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 3 9 hr. min.

9. Birthplace Mt. Sterling Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Marion Bell
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Ausmus
15. Birthplace Mt. Sterling Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Callie Petre
(b) Address Macon, Mo.

17. (a) Burial (b) Date thereof 4 8 19
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Salem, Macon, Co

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

19. (a) 5-7-48 (b) Quinn McNeely
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7th
year 1948 hour 7:00 minute _____ a. M.
21. I hereby certify that I attended the deceased from April 1 5th, 1948, to April 7th, 1948,
that I last saw her alive on April 7th 7:00 a.m., 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Stomach. Duration 6 mo.

Due to _____

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.

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 Dr. J. Carroll or other 70
Address Macon Date signed 4/7/48

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

JUL 24 1952

RECEIVED
District Health Officer No. 10
District File Number 548-862
Date Filed MAY 12 1948

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.....

Thos. L. Booth....., Registered Apprentice No. 37
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.