

FILED JUN 7 1948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17833

Registrar's No. 4907

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital, D
(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 Illinois (b) County Macon 999
(c) City or town..... Macon 11
(If outside city or town limits, write "RURAL") 0
(d) Street No. N.R. (If rural, give location) 2
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME MARA ELIZABETH METCALF

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Guy Metcalf 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased October 4 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 7 24 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Dudley Porter

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

14. Maiden name May O. Prescott

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

16. (a) Informant Guy Metcalf

(b) Address Macon, Ill.

17. (a) Removal (b) Date thereof 5-28-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moweaqua, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) MAY 28 1948 (b) J. F. Bredich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28
year 1948 hour 120 minute 25 A.M.

21. I hereby certify that I attended the deceased from May 26 1948 to May 28 1948
that I last saw ER alive on MAY 28 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor, malignant Duration
JH

Due to.....
Due to.....

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy As above

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 J. B. Bradley (M. D. or other) 0

Address Barnes Hospital Date signed 5/28/48

4907

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. W. Wilkinson

Licensed Embalmer No.....

3575

P. O. Address.....

St. Louis 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.