

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26981
Registrar's No. 375

FILED SEP 10 1948

Registration District No. 200

Primary Registration District No. 3041

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

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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Mary J. Quinn
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro
6. (a) 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 April 8 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 4 0 hr. min.

9. Birthplace College Mound Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Mose Gorham
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Delia Tillman
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. May Carry
(b) Address Macon, Mo.

17. (a) Burial (b) Date thereof 8/10/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation College Mound, Mo.

18. (a) Signature of funeral director Albert Hoover
(b) Address Macon

19. (a) 9-4-48 (b) Paul McNeely
(Date received local registrar) (Registrar's signature)

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. 503 Broadway
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8
year 1948 hour 3 minute 30 a.M.

21. I hereby certify that I attended the deceased from Aug 5, 1948, to Aug 8, 1948
that I last saw her alive on Aug 7, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocardial Failure
Due to Chronic Myocardial Failure
Due to Hypertensive Interchange
Of Arteriosclerosis
(Include pregnancy within 3 months of death)

Duration

several years

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy 9 3 15

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) Means of injury _____
23. Signature G. L. Surdick, D.O.
Address Macon Date signed 8/9/48

RECEIVED

District Health Officer No. 10

District File Number 448-1595

Date Filed SEP-9-1948

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Albert Skinner

Licensed Embalmer No. 757

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.