

FILED DEC 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37710**
Registrar's No. **136**

BIRTH NO. _____ **REG. DIST. NO.** 200 **PRIMARY REG. DIST. NO.** 3041

1. PLACE OF DEATH
a. COUNTY Macon

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY Macon

3. CITY OR TOWN Macon **c. LENGTH OF STAY** (In this place) 3 days

4. CITY OR TOWN Callao **d. STREET ADDRESS** (If rural, give location) Rural

5. NAME OF DECEASED
a. (First) Cora b. (Middle) Ann c. (Last) Mott

6. DATE OF DEATH (Month) (Day) (Year) 10 13 50

7. SEX Female **8. COLOR OR RACE** White **9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) Widowed

10. DATE OF BIRTH 8-2-83 **11. AGE** (In years last birthday) 67 **12. IF UNDER 1 YEAR** (Month) (Day) (Year) _____ **13. IF UNDER 48 HRS.** (Hour) (Min.) _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic **10b. KIND OF BUSINESS OR INDUSTRY** _____

11. BIRTHPLACE (State or foreign country) Monticello Illinois **12. CITIZEN OF WHAT COUNTRY?** USA

13a. FATHER'S NAME Walton J. McCammon **13b. MOTHER'S MAIDEN NAME** Samanthia Stultz **14. NAME OF HUSBAND OR WIFE** _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No **16. SOCIAL SECURITY NO.** _____ **17. INFORMANT'S SIGNATURE OR NAME** Ernestine Frost **ADDRESS** Callao, Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
**This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.*

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension arterial
INTERVAL BETWEEN ONSET AND DEATH 3 Days
b. Cerebral Hemorrhage
c. Hypertension arterial
d. unknown

2. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION _____ **19b. MAJOR FINDINGS OF OPERATION** _____ **20. AUTOPSY?** YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ **21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)** _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ **21e. INJURY OCCURRED WHILE AT WORK** NOT WHILE AT WORK **21f. HOW DID INJURY OCCUR?** _____

22. I hereby certify that I attended the deceased from 9-12 1950 **to** 10-13 1950, **that I last saw the deceased alive on** 10-13 1950, **and that death occurred at** 6:30 AM, **from the causes and on the date stated above.**

23a. SIGNATURE [Signature] (Degree or title) MD **23b. ADDRESS** Macon Mo. **23c. DATE SIGNED** 11-3-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** 10-15-50 **24c. NAME OF CEMETERY OR CREMATORY** Mt. Zion Cemetery **24d. LOCATION** (City, town, or county) (State) Callao Mo.

DATE REC'D BY LOCAL REG. 11-14-50 **REGISTRAR'S SIGNATURE** Ruth McNeely **25. FUNERAL DIRECTOR'S SIGNATURE** [Signature] **ADDRESS** Bevier, Mo.

0618

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

RECEIVED 12.11.50
MACON COUNTY HEALTH DEPARTMENT
County File No. 12.50.222
Date Filed 12.12.50

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

M. S. Edwards

Signed.....
Student Embalmer

Licensed Embalmer No. 1961

P. O. Address *Reverie 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.