DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Dr Gronoway

NOV 20 1940

State File No. 35778

Registration District No. 533 Primary Registration District No. 3027 Registrar's No. 66

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 2 (Specify whether

In this community 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) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ella Nora Dameron

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 Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 8 Feb 14 1864 (Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 11 If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

FATHER
12. Name Orlando Stolp
13. Birthplace Dont Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Betsy Graves
15. Birthplace New York (City, town, or county) (State or foreign country)

16. (a) Informant's own signature R. T. Dameron

(b) Address Macon Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27-40 (Month) (Day) (Year)

(c) Place: burial or cremation Callao Mo

18. (a) Signature of funeral director Albert Skinner

(b) Address Macon Mo

19. (a) 11/9/40 (Date received local registrar) (b) Leota Newton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year 1940 hour 4:50 minute a M.

21. I hereby certify that I attended the deceased from Oct 23, 1940 to Oct. 25, 1940 that I last saw her alive on Oct. 24, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	48 hrs
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? 476 (Specify type of place)

While at work? (e) Means of injury

23. Signature P. P. Gronoway (M. D. or other)

Address Macon, Mo Date signed 11/9/40

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 8-17-39 I X19511

RECEIVED
District Health Officer No. 10
District File Number 11-40-2121
Date Filed NOV 13 1940

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 George Hill

Licensed Embalmer No. 4066

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, above space should be left blank.