

U. S. No. 2
FORM-2-43
Rev. 5-17-39
X35697

Turn 25149

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 1 1944

Registration District No. 200

Primary Registration District No. 3041

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: Samaritan Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 90 days
(Specify whether years, months or days)

In this community 75 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon

(c) City or town Judson
(If outside city or town limits, write "RURAL")

(d) Street No. Macon, Mo
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Anna Vaughn

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3
year 1944 hour 7:30 minute a M.

21. I hereby certify that I attended the deceased from Mar 1944, to June 28, 1944
that I last saw her alive on June 28, 1944
and that death occurred on the date and hour stated above.

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 July 18, 1885
(Month) (Day) (Year)

Immediate cause of death
Senility with inanition & exhaustion
(progressive deterioration)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years 86 Months 4 Days 15
If less than one day _____ hr. _____ min.

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

Major findings: 162 lb

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name John Evans

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

14. Maiden name Elyah Horace

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

16. (a) Informant Laura Horace

(b) Address New Cambria Mo

17. (a) removal (b) Date thereof July 5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beverly Cem

18. (a) Signature of funeral director Robert Skyring

(b) Address Macon

19. (a) 7/6/44 (b) Yorata B. Hunkler
(Date received local registrar) (Registrar's signature)

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature J. F. Turner Secretary
Address Macon, Mo (M. D. or other) _____
Date signed 7/6/44

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

1
3
2

1037

RECEIVED

District Health Officer No. 10

District File Number 8-44-1454

Date Filed AUG 11 1944

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 Skumir

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.