V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30262

State File No.

Registration District No. 47 Primary Registration District No. 5169 Registrar's No. 274

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Williamsburg Trine Mill
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: / Prairie Ter
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Callaway 14

(c) City or town Williamsburg 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mattie V. McCracken

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife

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

7. Birth date of deceased May 21 1872 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
73	3	10	hr. min.

9. Birthplace Williamsburg, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Widow

11. Industry or business

FATHER
12. Name Thomas Yates
13. Birthplace Callaway County, Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Katie E. Lantry
15. Birthplace Callaway Co., Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant T. L. Yates
(b) Address Williamsburg, Mo.

17. (a) Burial (b) Date thereof 9/3/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Williamsburg, Mo.

18. (a) Signature of funeral director Chas Lunsford
(b) Address Mexico, Mo.

19. (a) 9-3-1945 (b) Josie Morsinkhoff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 2nd day
year 1945 Hour 1 PM minute M.

21. I hereby certify that I attended the deceased from
1940, to Sept 2, 1945
that I last saw her alive on in August 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Chronic.

Due to Gen Arterio Sclerosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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?
(Specify type of place)

While at work (e) Means of injury

23. Signature R. Crews (M. D. or other)

Address Fulton Mo Date signed 9/3/45

1147

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 10-3-45

OCT - 8 1945

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.....

Licensed Embalmer No. 3564

P.O. Address.....

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.