

No. 2
5-13
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30957**
Registrar's No. **90**

FILED SEP 20 1945
Registration District No. **2020**

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

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

3. (a) PRINT FULL NAME Fanny Whitaker
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 8
year 1945 hour 9 minute P M.
21. I hereby certify that I attended the deceased from Jan 1941 to Aug 8 1945
that I last saw her alive on Aug 8 1945
and that death occurred on the date and hour stated above.

4. Sex F 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 18 - 1867
(Month) (Day) (Year)

Immediate cause of death Cerebral thrombosis Duration 1 day 5
Due to _____
Due to _____

8. AGE: Years 78 Months 2 Days 21 If less than one day _____ hr. _____ min.
9. Birthplace La Grange Ill
(City, town, or county) (State or foreign country)
10. Usual occupation House wife

Other conditions Thyroiditis with decomp. Sw 45
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy g 40

11. Industry or business _____
12. Name John Adams
13. Birthplace No Record 9
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Ueack
15. Birthplace Mo
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs Walter Baker
(b) Address Macon Mo
17. (a) removal (b) Date thereof Aug 8-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Carthage Ill
18. (a) Signature of funeral director Robert Skiffner
(b) Address Macon Mo
19. (a) 9/4/45 (b) Pr B. Dunker
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(c) 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 Howard Miller (M. D. certifier)
Address Macon Mo Date signed 8/9/45

(Licensed Embalmer's Statement on Reverse Side)

1037

RECEIVED

District Health Officer No. 10

District File Number 9-45-1441

Date Filed SEP 17 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 Albert Skinner

Licensed Embalmer No. 751

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.