

No. 2  
8-13  
7-39  
X37823

FILED MAR 8 1946

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 3841

Registrar's No. 23

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? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lora Besse

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 3rd year 1945 hour 1 minute 25 P.M.

21. I hereby certify that I attended the deceased from Sept. 20, 1945, to Dec. 3, 1945, and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife Clayton 6. (c) Age of husband or wife 17 years

7. Birth date of deceased Dec 17 (Month) (Day) 1876 (Year)

Immediate cause of death Cerebral Hemorrhage Duration 2 months

8. AGE: Years 68 Months 11 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Hypertension

Due to Arteriosclerosis

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

Major findings: Of operations (3)

12. Name Frank Bird

Of autopsy \_\_\_\_\_

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

14. Maiden name Elizabeth Benbarger

15. Birthplace Indiana (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant Anna Halsell

(b) Address Chicago Ill

17. (a) Burial (b) Date thereof 12-5-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Bethlehem Cem

18. (c) Signature of funeral director Stephens + Goodwin

(b) Address Macon Mo

19. (a) Jan 10-46 (b) Keith Meneely (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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury 2

23. Signature R. W. Maddox (M. D. or other) \_\_\_\_\_

Address Macon Mo Date signed 1/5/46

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

MOTHER, FATHER

185

RECEIVED

District Health Officer No. 1

District File Number 2-46-38

Date Filed MAR-7-1946

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.

Registered Apprentice No.

Signed

*A. L. Stephens*

Licensed Embalmer No.

3057

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Max.  
Registrar's No. \_\_\_\_\_

Registration District No. 200 Primary Registration District No. 3041

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

3. (a) PRINT FULL NAME Lora Besse  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife Clayton Besse 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 17 1923  
(Month) (Day) (Year)

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) Ill (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day 31 Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN

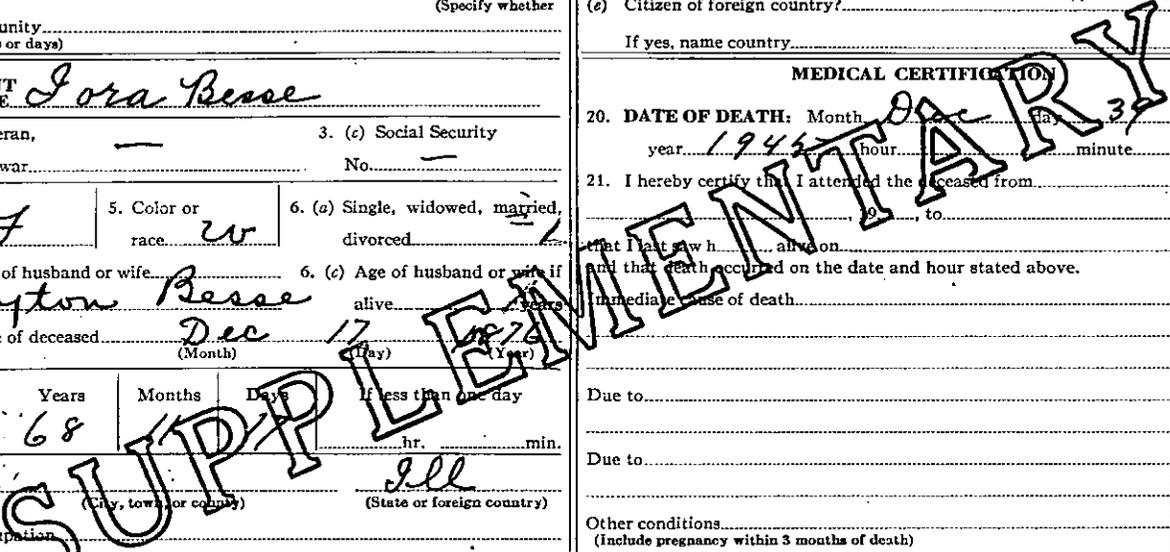
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



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