

No. 2
-9-43
-17-39
X 37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10065

FILED MAR 18 1946

Registration District No. 178

Primary Registration District No. 43-10 5719

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Bevier Rural
(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 Bevier Rural
(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 2 day 5
year 1946 hour 11 minute 30 P M.

21. I hereby certify that I attended the deceased from Nov 14 1945 to Feb 2 1946;
that I last saw her alive on FEB 2 1946
and that death occurred on the date and hour stated above.
Immediate cause of death CEREBRAL HEMORRHAGE Duration _____

Due to ARTERIOSCLEROSIS

Due to _____

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

Major findings:
Of operations _____

Of autopsy 830

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)

(c) Means of injury _____

Signature W. L. Chapman (M.D. or other) 20
Address Callao Mo Date signed 2-13-46

3. (a) PRINT FULL NAME SARAH E. FRAME

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 John Frame 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 22 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 5 13 - hr. - min.

9. Birthplace New Sharon Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name David R. Hughes
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Mary M. Best
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Edna Frame

(b) Address 925 73rd St. Kenosha Wis

17. (a) Rural (b) Date thereof 2-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Oakwood

18. (a) Signature of funeral director M. F. Edwards

(b) Address Bevier Mo

19. (a) 2-18-46 (b) Winnie Rowland
(Date received local registrar) (Registrar's signature)

1289 (Licensed Embalmer's Statement on Reverse Side)

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

8987

RECEIVED

District Health Officer No. 10

District File Number 3-46-461

Date Filed MAR 13 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

M. J. Edwards

Licensed Embalmer No. 1961

P. O. Address Bevier 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.