. No. 2
-11-10-39
5-17-39
1 X21

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14317

MAY 13 1940 85

Registration District No. ____ Primary Registration District No. 1001 Registrar's No. 404

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1815 Felix 9 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether In this community 79 years years, months or days) 624

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits write "RURAL") 0

(d) Street No. 1815 Felix (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME SARAH CAROLINE CRAIGHILL

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Samuel J. Craighill

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

7. Birth date of deceased June (Month) 9th. (Day) 1840 (Year)

8. AGE: Years 99 Months 9 Days 28 If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Wm. E. Barrow
13. Birthplace Harpers Ferry (City, town, or county) Va. (State or foreign country)

MOTHER
14. Maiden name Ann Forkerson
15. Birthplace unknown (City, town, or county) Scotland (State or foreign country)

16. (a) Informant Miss Nannie Craighill

(b) Address 1815 Felix St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 40 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora Cemetery

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) Apr. 8, 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7th. year 1940 hour 6 minute 00 a.m.

21. I hereby certify that I attended the deceased from March 14, 1940, to April 7, 1940, that I last saw her alive on April 5, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Suppression of urine uremia

Due to Chr. nephritis - arteriosclerosis

Due to Senility

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)

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While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) MD

Address 301 N 8 St Joseph Mo Date signed April 8 - 40

(Licensed Embalmer's Statement on Reverse Side)

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 C. G. Swan

Licensed Embalmer No. 4282

P. O. Address St Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.