

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

MAY 15 1940

Registration District No. 275

Primary Registration District No. 5170B

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Camden St. 71
 (b) City or town Richland (Route 17)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2

(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) 2123. (a) PRINT FULL NAME SARAH ANNA STARKS

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Frank Starks 6. (c) Age of husband or wife if alive None years

7. Birth date of deceased June 12 1859
(Month) (Day) (Year)

- | 8. AGE: | Years | Months | Days | If less than one day |
|---------|----------|-----------|-----------|----------------------|
| | <u>1</u> | <u>80</u> | <u>10</u> | hr. <u>1</u> min. |

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

10. Usual occupation Housewife

11. Industry or business

12. Name John Ewing 9
 13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Maudie Straw

- (b) Address Broken Arrow Okla.

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

- (c) Place: burial or cremation Mount View

18. (a) Signature of funeral director M. J. Super 119

- (b) Address Richland Mo

19. (a) April 10 1940 (b) Miss Maudie Pool Mooney
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Camden

- (c) City or town Richland (Route 1)
(If outside city or town limits, write "RURAL")

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1940 hour 11 1/2 minute 30 P.M.

21. I hereby certify that I attended the deceased from March 25, 1940, to March 29, 1940;
that I last saw her alive on March 29, 1940;
and that death occurred on the date and hour stated above.

- Immediate cause of death Broncho Pneumonia Duration 4 days

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)
(a) Means of injury _____

23. Signature Orest A. Oliver (M. D. or other) _____
Address Richland Mo. Date signed 3/29/40

10712

MS. 10M
4-15-5
195X 10

RECEIVED
District Health Officer No. 7,
District File Number 5-46-748
Date Filed 5-6-40

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..... *R. B. Leppin*.....

Licensed Embalmer No. *3198*.....

P. O. Address..... *Richland, W. Va.*.....

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14496

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 875

Primary Registration District No. 5170B

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cassidy
(b) City or town Stoutland T.P.
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarah Anna Starks

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 20, 1940 (b) Mrs Mae Pool Mooney (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 29 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to W

Due to _____

Other conditions none (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 Evelyn A. Glover (M. D. or other) _____
Address Richland _____ signed _____

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

SUPPLEMENTAL

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

S-14496