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13-40  
7-39  
X23159

Registration District No. 85

Primary Registration District No. 1001

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

Registrar's No. 801

1. PLACE OF DEATH:

(a) County BUCHANAN 3

(b) City or town ST-JOSEPH

(c) Name of hospital or institution: NURSEING-HOME-1823 NO 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution INSTITUTION  
(Specify whether)

In this community 3 MO - 22 DAYS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BUCHANAN

(c) City or town ST-JOSEPH  
(If outside city or town limits, write "RURAL")

(d) Street No. 1823 No 2 NO  
(If rural, give location)

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

3. (a) PRINT FULL NAME CYRUS - SADLER

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24  
year 1940 hour 6 minute 30P M.

4. Sex MALE

5. Color or race WHT.

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

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

7. Birth date of deceased: May 1 20 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 22, 1940 to July 24, 1940  
that I last saw him alive on July 22, 1940, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage (Apoplexy)

8. AGE:	Years	Months	Days	hr.	min.
	<u>79</u>	<u>2</u>	<u>4</u>		

Due to: Hypertension (H.W.) unknown

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

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

10. Usual occupation: Farmer

11. Industry or business: Self

Other conditions: Arterio-sclerosis unknown  
(Include pregnancy within 3 months of death)

Major findings: Senility

Of operations: \_\_\_\_\_

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

MOTHER FATHER

12. Name: Moses Sadler

13. Birthplace: unk Penn  
(City, town, or county) (State or foreign country)

14. Maiden name: Anna

15. Birthplace: unk Ohio  
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant: Records at County Farm

(b) Address: St Joseph MO

17. (a) buried (b) Date there: July 27 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Oakland Cemetery

18. (a) Signature of funeral director: Ray Blaney

(b) Address: St Joseph MO

19. (a) 7/26/40 (b) W. J. Nestledick  
(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? 85

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

(e) Means of injury \_\_\_\_\_

23. Signature: Maxwell Day (M. D. or other) \_\_\_\_\_  
Address: 214 N 7th St Joseph Date signed: 7-26-40

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

218 N 7th Des Moines

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.....

July 24 1940

Registered Apprentice No. ....

working under my personal supervision.

Signed

John L. Hurley

Licensed Embalmer No. 4050

P. O. Address St Joseph 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.