

INDEXED SEP 23 1940

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Mount Vernon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri State Sanatorium,  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 mos. 11 das. (Specify whether  
In this community 7 mos. 11 das. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon  
(c) City or town Horton (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. Not known (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9  
year 1940 hour 6 minute 15 a.m.  
21. I hereby certify that I attended the deceased from DEC. 30  
1939 to Aug. 8 19 40  
that I last saw her alive on August 8 19 40  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 18 mos.

3. (a) PRINT FULL NAME Lena Mae Sapp 100

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. Not known

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

6. (b) Name of husband or wife Not known 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. March 19 1913  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>27</u>	<u>4</u>	<u>22</u>	hr. _____ min. _____

9. Birthplace: Vernon County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name David Grant Stickley 1  
18. Birthplace Not known Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Clara Mae Walden  
15. Birthplace Not known 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel McMichael

(b) Address Missouri S. San. Mt. Vernon, Mo

17. (a) Burial (b) Date thereof Aug 14 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mr. Staley Sanatorium, Room 421

18. (a) Signature of funeral director Jessie Funeral Home

(b) Address Mt. Vernon, Mo

19. (a) 8-14-40 (b) P.A. HOLMES  
(Date received local registrar) (Registrar's signature)

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

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

Other conditions \_\_\_\_\_  
(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? \_\_\_\_\_

(e) Means of injury \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

23. Signature Dr. C. E. Hellweg (M. D. or other) \_\_\_\_\_

Address Mt. Vernon, Mo Date signed 8-9-40

Disposition

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6

District File Number 440-2539

Date Filed SEP 6 1947

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**