SEP 25

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

29978

State File No.

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 199

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

1. PLACE OF DEATH:

(a) County Vernon Wood Mo

(b) ~~City or town~~ Nevada
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Hosp # 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yr 5 mo - 1 da (Specify whether
In this community 3 yr 5 mo 1 da
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jasper

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown
(If rural, give location)

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

3. (a) PRINT FULL NAME Sarah M. Sloan 450

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar (Month) 2 (Day) 1863 (Year)

8. AGE: Years 77 Months 4 Days 29 If less than one day hr. min.

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

10. Usual occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Hosp record St Hosp. # 3
(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/40 (Month) (Day) (Year)
(c) Place: burial or cremation St Hospital Cemetery

18. (a) Signature of funeral director Terry Funeral Home
(b) Address Nevada, Mo.

19. (a) 8-8-40 (Date received local registrar) (b) Allen V Hays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1
year 1940 hour 1 minute 15 P M.

21. I hereby certify that I attended the deceased from Feb 24, 1937, to Aug 1, 1940
that I last saw h alive on , 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocardial insufficiency.	
Due to: General Paralysis of the insane	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature F L Martin (M. D. ~~or other~~) 1
Address St Hosp # 3 Date signed 8/1/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 9-40-1252
Date Filed 8-8-40

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~~ Personal

....., Registered Apprentice No.....

working under my personal supervision.

Signed Lloyd R. Winscott

Licensed Embalmer No. 3857

P. O. Address Nevada, Mo.

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

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