No. 2
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17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34805

Registration District No. 8501 Primary Registration District No. 1001 Registrar's No. 1064

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: 520 Thompson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town Saint Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 520 Thompson
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years

3. (a) PRINT FULL NAME SARAH VIRGINIA PURCELL

3. (b) If veteran, name war none

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 James Calvin

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

7. Birth date of deceased January (Month) 14 (Day) 1851 (Year)

8. AGE: Years 89 Months 8 Days 24 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Peter Torode
13. Birthplace unknown (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Catherine Brown
15. Birthplace unknown (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Mrs. H.W. Ford
(b) Address 520 Thompson, city

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10-11-40 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Fleeman & Son, Inc
(b) Address St. Joseph, Missouri

19. (a) Oct 8-1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 80 year 1940 hour 1 minute 30 A M.

21. I hereby certify that I attended the deceased from April 11, 1940, to Oct. 8, 1940; that I last saw her alive on Oct. 7, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arterio-sclerosis - general	
Due to: Myocardial Insufficiency	do not know
Due to: unknown	
Other conditions (Include pregnancy within 3 months of death): Cystitis. Dehydration	7 da.

Major findings:
(a) Of operations none
Of autopsy no 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 C. S. Grant (M. D. or other) DMD.
Address St. Joseph, Mo. Date signed 10-8-40

(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 Carl W. Haws

Licensed Embalmer No. 3955

P. O. Address St. Joseph, Mo.

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

If this body is not embalmed, fact should be so stated above.