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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35376

Registration District No. 944

Primary Registration District No. 5447-B

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution Stratford Mo. R. # 1
(If not a 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. Stratford Route # 1
(If rural, give location)

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

3. (a) PRINT FULL NAME DORA LEE SANDERS

(b) If veteran, name war None

(c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26th
year 1940 hour 4 minute A M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive None years

7. Birth date of deceased October 25 1940
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 25, 1940
_____ 19____ to Oct 26 _____, 1940;
that I last saw her alive on Oct 25 _____, 1940;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

0 0 1 hr. _____ min.

Immediate cause of death Prematurity 6 1/2 mo.

Due to _____

Due to _____

9. Birthplace Stratford Route # 1 Missouri
(City, town, or county) (State or foreign country)

Other conditions 15 1/2
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation None

11. Industry or business None

MOTHER FATHER

12. Name James S. Sanders

13. Birthplace Bolivar Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Cora Jones

15. Birthplace Springfield Mo.
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant James S. Sanders

(b) Address Stratford Mo. R. # 1

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? _____

17. (a) Burial (b) Date thereof Oct. 27, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Methodist

18. (a) Signature of funeral director G. C. Owens

(b) Address Springfield Mo.

19. (a) Oct. 27, 1940 (b) Harry Greer
(Date received local registrar) (Registrar's signature)

23. Signature E. T. McClintock or other _____
Address Springfield, Mo. 10/26/40

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

RECEIVED

Greene County Health Office,

County File Number 40-11-91

Date Filed 11/2/40

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.....

Was not Embalmed, Registered Apprentice No.....
working under my personal supervision.

Signed R. H. Thomas

Licensed Embalmer No. 3651

P. O. Address Springfield, 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.