

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

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21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

44144

State File No. _____

Registration District No. 871

Primary Registration District No. 4525

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution:
Mitz, Mo
(If not in hospital or institution, write street number or location)

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

In this community 30 yrs (Specify whether _____ years, months or days) 20

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon

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

(d) Street No. Street not named
(If rural, give location)

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

3. (a) PRINT FULL NAME Sarah Elizabeth Rynard

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16, year 1940 hour 2:30 minute A M.

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

6. (b) Name of husband or wife Joseph Rynard 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 11 1954
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 23, 1940 to Dec 16, 1940 that I last saw her alive on Nov 30, 1940 and that death occurred on the date and hour stated above.

8. AGE:

| | | | |
|-----------|-----------|-----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>86</u> | <u>10</u> | <u>15</u> | hr. _____ min. _____ |

Immediate cause of death Endocarditis Spuit
Known

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

10. Usual occupation Housekeeper

11. Industry or business Home

Due to Advanced age.

Due to _____

Other conditions g2p
(Include pregnancy within 3 months of death)

MOTHER FATHER

12. Name Maria M. Summers

13. Birthplace Unknown Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Mary E. Welch

15. Birthplace Unknown Tenn.
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant L. H. Summers

(b) Address Nevada, Mo.

17. (a) Burial (b) Date thereof 12/18/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Balltown Cemetery

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

(b) Address Nevada, Mo

19. (a) 12/20/40 (b) Thelma Wilson
(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? 856

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature J. M. Love (M. D. or other) _____

Address Nevada Mo. Date signed 12/16/40

RECEIVED

District Health Officer No. 7,

District File Number 1-41-60

Date Filed 1-9-41

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 Lloyd R. Winsett

Licensed Embalmer No. 3857

P. O. Address Wada, Mo

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

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