S. No. 2
—4-13-40
v. 5-17-39
I X23139

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14517

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 280

39
2
6

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 872 So. Grant
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether
In this community 66 Years / years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL") 6
(d) Street No. 872 So. Grant.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Sarah Elizabeth Nearguard
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race Colored
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Wm Nearguard
6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased July (Month) 4 (Day) 1864 (Year)

8. AGE: Years 76 Months 8 Days 28 If less than one day ___ hr. ___ min.

9. Birthplace Unknown (City, town, or county) Tenn. (State or foreign country) 1
10. Usual occupation Domestic
11. Industry or business None
MOTHER FATHER
12. Name James Gaines
13. Birthplace Unknown (City, town, or county) Tenn. (State or foreign country) 1
14. Maiden name Angeline Ray
15. Birthplace Unknown (City, town, or county) Tenn. (State or foreign country) 1
16. (a) Informant Orin Nearguard
(b) Address 619 No. Wearer Springfield
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Hazelwood Cem.
18. (a) Signature of funeral director W. Campbell
(b) Address 867 Washington Ave.
19. (a) 4-4-41 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2
year 41 hour 5:30 minute P. M.
21. I hereby certify that I attended the deceased from 8/26/39
, 19__, to April 2, 1941;
that I last saw her alive on April 2, 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocarditis	1½ yrs.
Due to	
Due to	
Other conditions Senility (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? 9.84 (Specify type of place)
While at work? (e) Means of injury
23. Signature Gordon C Looney (M. D. ~~or other~~) 111
Address 1020 Sherman Date signed 4-4-41

(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 W. P. Campbell, Registered Apprentice No. ..... working under my personal supervision.

Signed W. P. Campbell

Licensed Embalmer No. 1747

P. O. Address Springfield Ill

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.