

Registration District No. **FILED DEC 3, 1941**

Primary Registration District No. **6239**

Registrar's No. **18**

1. PLACE OF DEATH:

(a) County **Barry**
 (b) City or town **Exeter Route**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **Exeter, Mo. Route**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **no** (Specify whether)
 In this community **all her life** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**
 (c) City or town **Exeter Route**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **7. W. Exeter** (If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME

Annie Sapp

3. (b) If veteran, name war **0**

3. (c) Social Security No. **0**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Samford N. Sapp** 6. (c) Age of husband or wife if alive **44** years
 7. Birth date of deceased **April 12 1889**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 6 22 hr. min.

9. Birthplace **Barry County, Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

MOTHER FATHER

11. Industry or business
 12. Name **George S. Reed**
 13. Birthplace **Kentucky**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Mary Ellen Hayes**
 15. Birthplace **Barry County, Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Samford Sapp**
 (b) Address **Exeter Mo. Route**
 17. (a) **Burial** (b) Date thereof **Nov. 5-1941**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Maplewood Cemt.**

18. (a) Signature of funeral director **Boon Funeral Home**
 (b) Address **Cassville Mo.**
 19. (a) **Nov. 5-1941** (b) **Mrs. H. P. Seavey**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** Day **4th**
 year **1941** hour **9** minute **A. M.**
 21. I hereby certify that I attended the deceased from **Oct. 30**
 19**41**, to **Nov. 2** 19**41**;
 that I last saw her alive on **Nov 2** 19**41**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **malnutrition**
 Due to **Generalized Tuberculosis**
 Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

22b

Of autopsy

Duration

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? (c) Means of injury

23. Signature **W. R. M. Clure** (M. D. or other)
 Address **Cassville** Date signed **11/5/41**

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

RECEIVED

District Health Officer No. 6,

District File Number 1241-1746

Date Filed DEC 5 1949

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..... *Howard R. Haman*

Licensed Embalmer No. 4122.....

P. O. Address Cassville, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Bural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in 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..... (b) County.....
(c) City or town.....
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

Lucie Lapp

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years 52 Months 6 Days 14 If less than one day..... min.

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

10. Usual occupation.....

11. Industry of business.....

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

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

16. (a) Informant.....
(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Jan. 9. 42 (b) Mrs. H. P. Lacey
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
..... 19.....
that I last saw him..... live on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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?
.....

While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature..... (M. D. or other).....

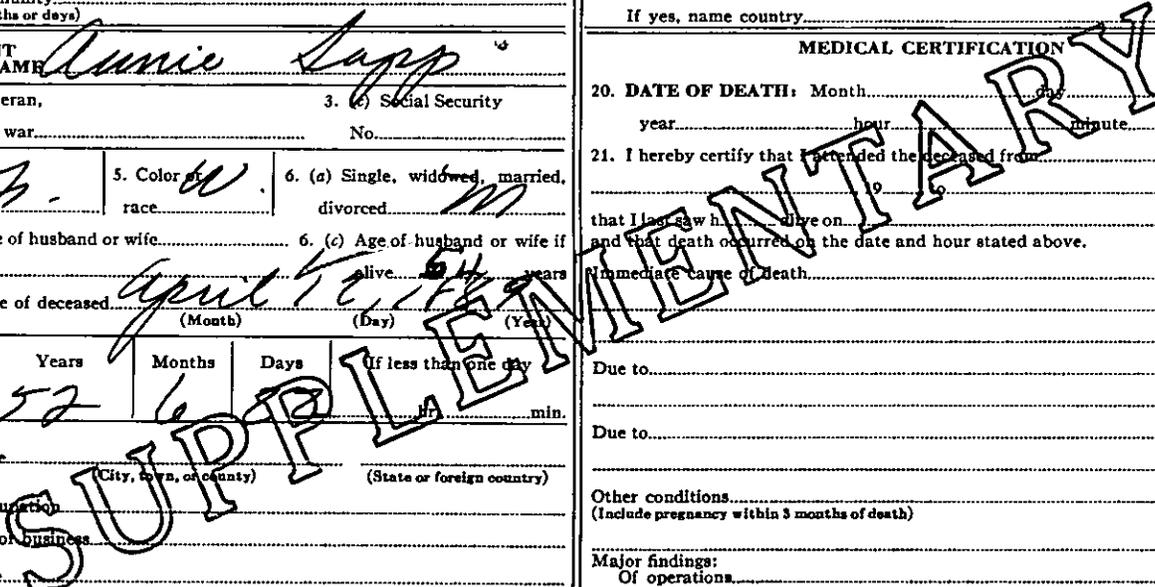
Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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



5-37761