

No. 2
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26390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22447

ED JUL 15 1942

State File No. _____

Registration District No. 938

Primary Registration District No. 6098B

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Dexter, Mo. R. 1.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Missouri (b) County Stoddard ¹⁰³
(c) City or town Dexter, R. 1. ⁰
(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 _____ ⁰

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Sarah Ida Morris

20. DATE OF DEATH: Month June day 18
year 1942 hour 12 minute 5 A. M.

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

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

Immediate cause of death _____
Hemorrhage of Lungs ^{Duration}
Strangled

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

Due to Age

7. Birth date of deceased Feb. 13. 1868
(Month) (Day) (Year)

Due to _____

8. AGE: Years 74 Months 4 Days 5 If less than one day _____ hr. _____ min.

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

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

Major findings:
Of operations _____

10. Usual occupation House Keeper

Of autopsy no.

11. Industry or business _____

22. If death was due to external causes, fill in the following:

12. Name Ben M. Unger

(a) Accident, suicide, or homicide (specify) _____

13. Birthplace unknown ⁷
(City, town, or county) (State or foreign country)

(b) Date of occurrence _____

14. Maiden name unknown ⁹

(c) Where did injury occur? _____ (City or town) (County) (State)

15. Birthplace 88 ⁹
(City, town, or county) (State or foreign country)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant Mrs. Stella M Wilson

While at work? _____ (Specify type of place) (b) Means of injury _____

(b) Address Dexter, Mo. R. 1.

23. Signature J. E. Bobbitt (M.D. or other) _____

17. (a) Burial (b) Date thereof June 19 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

Address King Coroner Date signed 6/18-42

(c) Place: burial or cremation Puxico, Mo.

18. (a) Signature of funeral director Watkins Funeral Ser.

(b) Address Dexter, Mo.

19. (a) 6-26-42 (b) Nora Smith
(Date received local registrar) (Registrar's signature)

1134 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 742-866

Date Filed JUL 13 1942

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 B. J. Brentlinger

Licensed Embalmer No. 4201

P. O. Address Dexter, 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. 22447

Registration District No. 839

Primary Registration District No. 6098B

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural
(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 Sarah Ida Morris

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

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

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

7. Birth date of deceased Feb 13 1894
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days _____
(If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 1942 year. hour _____ minute 2 A.M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ days on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death Renard's disease due to tubercular
Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 1142

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?

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

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

Address _____ Date signed _____

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

MOTHER, FATHER

SUPPLEMENTAL

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NOV

S-22447