

FILED NOV 18 1944
Registration District No. 244

Primary Registration District No. 5834

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Sarcoxie Rural Marion twsp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 49 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton
(c) City or town Sarcoxie R.F.D. 1
(If outside city or town limits, write "RURAL.")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Ida A. Garber

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, married
6. (b) Name of husband or wife Jacob 6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased May 1, 1869
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 2 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Dont know
13. Birthplace dont know
(City, town, or county) (State or foreign country)
14. Maiden name Dont know
15. Birthplace dont know
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Jacob Garber

(b) Address Sarcoxie, Mo., #1

17. (a) Burial (b) Date thereof 10/6/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garber Cemetery

18. (a) Signature of funeral director Roland C. Engelage

(b) Address Sarcoxie, Missouri

19. (a) Oct 5-1943 (b) Mrs. W. S. Chapman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3 year 1943 hour 1:15 minute A. M.
21. I hereby certify that I attended the deceased from July 16 1943 to Sept 16 1943
that I last saw h. alive on Sept 28 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration 6 days

Due to Two other attacks

Due to ✓

Other conditions (Include pregnancy within 3 months of death) gza!

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 Leah Bragdon (M. D. or other)
Address Needles Mo Date signed 10/4-43

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

2
12
39
32873

RECEIVED

11-10-43
District Health Officer No. _____

District File Number 1143-207

Date Filed 11-15-43

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 _____

Licensed Embalmer No. 946

P. O. Address _____
Mr. Vernon J.

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.