

FILED JAN 10 1944  
338

State File No. ....

Registration District No. 338

Primary Registration District No. 4501

Registrar's No. ....

1. PLACE OF DEATH:

(a) County **Stoddard**

(b) City or town **Bloomfield**  
(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** \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Stoddard**

(c) City or town **Bloomfield**  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME **Sarah Jane Gwaltney**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **4**  
year **1943** hour **1** minute **10 a.** M.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Chas. Gwaltney** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **March 10 1875**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Nov. 15** 19**43** to **Nov. 24** 19**43**  
that I last saw **her** alive on **Nov. 24** 19**43**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**68** **8** **24** \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Cerebral Hemorrhage** Duration **20 days**

9. Birthplace **Mo. 0**  
(City, town, or county) (State or foreign country)

Due to **ARTERIO SCLEROSIS**

10. Usual occupation **Housewife**

Due to \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

MOTHER FATHER { 12. Name **John Dennis**

Major findings: Of operations \_\_\_\_\_

13. Birthplace **Mo. 0**  
(City, town, or county) (State or foreign country)

Of autopsy \_\_\_\_\_

14. Maiden name **Angeline Jackson**

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

15. Birthplace **Mo. 0**  
(City, town, or county) (State or foreign country)

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

16. (a) Informant **Chas. Gwaltney**

(b) Date of occurrence \_\_\_\_\_

(b) Address **Bloomfield, Mo.**

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

17. (a) **Burial** (b) Date thereof **Dec. 6, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

(c) Place: burial or cremation **Brush Creek Cemetery**

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

18. (a) Signature of funeral director **Chiles Und. Co.**

23. Signature **D. Shaver** (Specify type of place) (b) D. or other \_\_\_\_\_

(b) Address **Bloomfield, Mo.**

19. (a) **12-29-1943** (b) **Real Chiles**  
(Date received local registrar) (Registrar's signature)

Address **BLOOMFIELD, Mo. 645-43**

1130

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

RECEIVED

District Health Office No. 2,

District File Number 148-49

Date Filed 1-7-43

**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 Juan C. Cooper.....

Licensed Embalmer No. 4119.....

P. O. Address Bloomfield, 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.**