

FILED MAR 9 1944  
373

Registration District No. **373**

Primary Registration District No. **6067**

Registrar's No.

1. PLACE OF DEATH:

(a) County **St Clair**  
(b) City or town **Rural, Speedwell Twp**  
(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 **ST CLAIR** **93**  
(c) City or town **RURAL**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **SPEEDWELL TOWNSHIP**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **18**  
year **1944** hour **6** minute **0** M.

21. I hereby certify that I attended the deceased from **2-8** 1944 to **2-16** 1944  
that I last saw her alive on **2-16** 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death **lobar pneumonia**  
Due to **unknown**  
Duration **two weeks**

Other conditions (Include pregnancy within 3 months of death) **100**

Major findings: Of operations **none**  
Of autopsy **no**  
PHYSICIAN **100**  
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) **no**  
(b) Date of occurrence **none**  
(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? **no** (Specify type of place) \_\_\_\_\_  
(e) Means of injury **no**  
23. Signature **J.W. Richardson** (M. D. or other)  
Address **Piffin** Date signed **2-19-44**

3. (a) PRINT FULL NAME **SARAH L. CORBIN**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **none**

4. Sex **FEMALE** Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**

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

7. Birth date of deceased **March 29 1861**  
(Month) (Day) (Year)

8. AGE: Years **82** Months **10** Days **19** If less than one day hr. min.

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

10. Usual occupation **housewife**

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

12. Name **Moses Busbee**

13. Birthplace **Ind 1** (City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Plank**

15. Birthplace **Ind 1** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs August Macchewski**

(b) Address **R. 2, El Dorado Springs, Mo**

17. (a) **Burial** (b) Date thereof **2-20-1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Pleasant (Cem)**

18. (a) Signature of funeral director **Kevin Siders**

(b) Address **El Dorado Springs, Mo**

19. (a) **Feb 21, 1944** (b) **A. B. Goodrich**  
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 7,

City of Kansas

Dist. No.

2-44-294  
3-8-44

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 *W. B. Bideris*

Licensed Embalmer No. *3250*

P. O. Address *W. B. Bideris*

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.