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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 27 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10515

Registration District No. 43 — Primary Registration District No. 5143 — Registrar's No. 80

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Rural Ringo Ford Resort (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Poplar Bluff twp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether In this community 2 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butler 12 0

(c) City or town Ringo Ford Resort (If outside city or town limits, write "RURAL")

(d) Street No. Rural - Poplar Bluff (If rural, give location)

(e) Citizen of foreign country? Mo. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Sarah Skradling

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. 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 Aug. (Month) 15. (Day) 1871 (Year)

8. AGE: Years 72 Months 5 Days 8 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Mat Trammel
13. Birthplace ..... (City, town, or county) Illnois (State or foreign country)

MOTHER
14. Maiden name Jane Boyd
15. Birthplace ..... (City, town, or county) Illnois (State or foreign country)

16. (a) Informant Orval Johnson

(b) Address Fairdealing Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Bethel cemt.

18. (a) Signature of funeral director Blacks Mortuary

(b) Address Doniphan Mo.

19. (a) 3-8-44 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 23. year 1944 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from 1/17 1944 to Jan 23 1944 that I last saw her alive on Jan 22 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar pneumonia

Due to .....

Due to .....

Other conditions hypertension with myocardial change (Include pregnancy within 3 months of death)

Major findings: Of operations .....

Of autopsy no

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? ..... (e) Means of injury .....

23. Signature [signature] (M. D. or other) [signature]

Address Naylor Mo. Date signed 3/29/44

92 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 344-532
Date Filed 3-22-44

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 Not Embalmed, Registered Apprentice No.....,
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.