

FILED AUG 4 1944  
Registration District No. 274

Primary Registration District No. 3052

1. PLACE OF DEATH:

(a) County PETTIS  
 (b) City or town SEDALIA  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
519 W 3RD ST.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether  
 In this community 27 YEARS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County PETTIS  
 (c) City or town SEDALIA  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 519 W. 3RD ST.  
(If rural, give location)  
 (e) Citizen of foreign country?.....  
If yes, name country.....

3. (a) PRINT FULL NAME MYRTLE ROSE  
 3. (b) If veteran, name war.....  
 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 2<sup>ND</sup>  
 year 1944 hour 3 minute P.  
 21. I hereby certify that I attended the deceased from Mon 4 1944  
 ....., 19.., to July 2, 19..  
 that I last saw h. u alive on July 2  
 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 MARRIED  
 6. (b) Name of husband or wife JOHN  
 6. (c) Age of husband or wife if alive 60 years  
 7. Birth date of deceased.....  
(Month) (Day) (Year)

Immediate cause of death Arteriosclerosis  
 Duration 7 days

8. AGE: Years Months Days If less than one day  
50 1 11 hr. min.

Due to Cerebral a. of uterine involving vessels.

9. Birthplace HUNNEWELL Mo.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation HOUSEWIFE

Other conditions (include pregnancy within 3 months of death)  
 Major findings: Of operations H&P  
 Of autopsy.....

11. Industry or business.....  
 12. Name WILLIAM T. SHERRY  
 13. Birthplace HUNNEWELL Mo.  
(City, town, or county) (State or foreign country)  
 14. Maiden name MARG. E. MAYS  
 15. Birthplace HUNNEWELL Mo.  
(City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant JOHN ROSE  
 (b) Address SEDALIA, MO  
 17. (a) BURIAL (b) Date thereof 7-4-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation CROWN HILL CEM.  
 18. (a) Signature of funeral director Gillespie  
 (b) Address SEDALIA  
 19. (a) 7/3/44 (b) Mrs Anna Berge  
(Date received local registrar) (Registrar's signature)

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 Chas Osborne (M. D. or other)  
 Address Sedalia Mo Date signed 7/3/44

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

664

RECEIVED

District Health Officer No. 8

District File Number

Dr. No. 8-4-44

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..... *Geo Willard* .....  
Licensed Embalmer No. *3868* .....  
P. O. Address..... *Sebalia* .....

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.