

Registration District No. 128

Primary Registration District No. 5462

Registrar's No. 5462

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Rural Franklinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Rt 2 Fair Grove
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 66 yrs years, months or days

3. (a) PRINT FULL NAME Sarah J. Starks
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frank B. Starks
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased Nov-1-1878
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Dallas Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation House Wife

11. Industry or business _____
12. Name Richard C. Bubbs
13. Birthplace KY (City, town, or county) (State or foreign country)
14. Maiden name Jocix Patten
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Frank B. Starks
(b) Address Rt 2 Fair Grove Mo
17. (a) Bural (b) Date thereof 1-5-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Union Grove

18. (a) Signature of funeral director J. W. Higgins
(b) Address Springfield Mo
19. (a) Jan 4, 1945 (b) Mrs. Pauli Dell
Date received local registrar (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rt 2 Fair Grove (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3
year 1945 hour 4 minute 45 P. M.
21. I hereby certify that I attended the deceased from Dec 10,
1944, to Jan 3, 1945
that I last saw h. er alive on Jan 3, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 12 hr.

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

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 Wayne Gormeray (M. D. or other) Dr.
Address Fair Grove Mo Date signed 1/4/45

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

MOTHER FATHER

1372

RECEIVED

Greene County Health Office,

County File Number _____

Date Filed _____

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 Roy A. Clavin

Licensed Embalmer No. 1769

P. O. Address Springfield 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.