

FILED FEB 13 1945

Registration District No. _____

Primary Registration District No. **5-5-5-13025**

Registrar's No. **19**

1. PLACE OF DEATH:
(a) County **Newell**
(b) City or town **West Plains, Mo**
(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) **1**
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Newell**
(c) City or town **West Plains**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Jehaida J. Sams**
3. (b) If veteran, name war
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH Month **1-2** day **28** year **44** hour **3** minute **30 a.** M.

4. Sex **mo** **5. Color or race** **w** **6. (a) Single, widowed, married, divorced.** **S.O.**
6. (b) Name of husband or wife. _____ **6. (c) Age of husband or wife if alive.** _____ years

21. I hereby certify that I attended the deceased from **Mich.** **1942** to **Dec.** **1944**
that I last saw him alive on _____ and that death occurred on the date and hour stated above.
Immediate cause of death: **cardiac failure**

7. Birth date of deceased **Apr 7**
(Month) (Day) (Year)
8. AGE: Years **78** Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to **Arteriosclerosis**
Due to **arteriosclerotic nephritis**

9. Birthplace **Arkansas**
(City, town, or county) (State or foreign country)
10. Usual occupation **Farmer**

Other conditions: _____ (Include pregnancy within 3 months of death)
Major findings: **13/a**

11. Industry or business _____
12. Name **J. J. Sams**
13. Birthplace **Arkansas**
(City, town, or county) (State or foreign country)
14. Maiden name **Martha Bishop**
15. Birthplace **Arkansas**
(City, town, or county) (State or foreign country)

Of autopsy **None**
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Elmer Sams**
(b) Address **West Plains, Mo**
17. (a) _____ **(b) Date thereof** **1/30-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Cem. West Plains**

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? _____

18. (a) Signature of funeral director **Robert Sams**
(b) Address **West Plains, Mo**
19. Jan 30-45 **(b)** **Saml. H. Vanhook**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
Signature **R. O. Sparks** (M. D. _____)
Address **West Plains, Mo** Date signed _____

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

6-1-1

RECEIVED
District Health Officer No. 5
District File No. _____
Date Filed _____

RECEIVED
District Health Officer No. 5
District File Number. 24573
Date Filed 2-8-45

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 None
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.