S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dn Cantyle

FILED SEP 13 1945

State File No. 28156

Registration District No. 277 Primary Registration District No. 3052 Registrar's No. 206

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bothwell Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 weeks (Specify whether

In this community since 1902. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis 80

(c) City or town Green Ridge (If outside city or town limits, write "RURAL")

(d) Street No. Streets not mindered (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Sarah Oliva Morrow.

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ Widowed

6. (b) Name of husband or wife John A Morrow

6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased Jan (Month) 13 (Day) 1863 (Year)

8. AGE: Years 82 Months 6 Days 23 If less than one day hr. min.

9. Birthplace Near Marsh (City, town, or county) Iowa (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Crawford
13. Birthplace Dont Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Jane Blue
15. Birthplace Dont Know (City, town, or county) (State or foreign country)

16. (a) Informant Martell Morrow

(b) Address 4806 Hudson Rd, Kansas City, Kans

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof Aug. 8 1945 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ Green Ridge Cem.

18. (a) Signature of funeral director L. L. Ream

(b) Address Green Ridge Mo

19. (a) 8/7/45 (Date received local registrar) (b) Mrs Anna Berger (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day 6 year 1945 hour 10 AM minute M.

21. I hereby certify that I attended the deceased from June 6, 1945 to Aug 6, 1945; that I last saw her alive on Aug 6th, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Senility	?
Due to Chronic Myocarditis	?
Due to Fracture of Rt Femur	6-5-45
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations None

Of autopsy None

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) Accident 80

(b) Date of occurrence 6-5-45 Fell at home

(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? In her home (Specify type of place)

While at work? (e) Means of injury

23. Signature Jno B. Carlisle M.D. (M. D. or other)

Address Sedalia Mo Date signed 8-7-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8

District File Number _____

Date Filed 9-12-45

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 L. L. Ream

Licensed Embalmer No. 1881

P. O. Address Green Ridge 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.