

No. 2
-5-42
-17-39
X32873

Registration District No. 354

Primary Registration District No. 6199

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Clinton +wp. Mtn Grove
(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)

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

In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas 107

(c) City or town Mountain Grove (Rural) 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME Lieu Dora Sails

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20
year 1945 hour 4 minute 30 P.M.

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife Nathan Sails 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 29 1866
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr. 1 - 1945 to May - 20 - 1945
that I last saw her alive on May - 19 - 1945
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>8</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death Cerebral thrombosis

Due to _____

Due to _____

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

10. Usual occupation At home

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name George Ellis

13. Birthplace Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Josephine McClain

15. Birthplace Scotland (City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

None

16. (a) Informant Douglas Sails

(b) Address Mountain Grove Mo

17. (a) Burial (b) Date thereof May 21, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friendship Cemetery

18. (a) Signature of funeral director Swamp Staff

(b) Address Mountain Grove Mo

19. (a) Sept 14 - 1945 (b) Mrs Lou Miller
(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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature D. W. Henry (M. D. or other) _____
Address Mtn. Grove Mo Date signed 5-21-45

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

MOTHER FATHER

1239

RECEIVED

District Health Officer No. 5

District File Number 1042528

Date Filed 10-13-45

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

George Stoff

Licensed Embalmer No.

5161

P. O. Address

Mt. Laurel Pa

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.

Registration District No. 354

Primary Registration District No. 6199

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(a) County Texas
(b) City or town Clinton Junc (rural)
(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)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 Lies Doris Sails

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased aug 2 (Month) (Day) (Year)

8. AGE: Years 18 Months _____ Days _____ If less than one day _____ hr. _____ min. mo

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1945 (hour) _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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 _____ (M. D. or other)

Address _____

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

SUPPLEMENTARY

31610