

NO. 2
8-43
-17-39
X37823

State File No. _____

FILED DEC 13 1945

Registration District No. 74

Primary Registration District No. 5-298

Registrar's No. 33-54

1. PLACE OF DEATH:

(a) County Clinton Co.
(b) City or town Rural Lafayette Twp.
(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 years, months or days)
In this community Entire Life

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18
year 1945 hour 2 minute 6 M.
21. I hereby certify that I attended the deceased from 4-30
1945 to 11-19 1945
that I last saw him alive on 10-8 1945
and that death occurred on the date and hour stated above.

Immediate cause of death ruptured following fractured hip
Due to _____
Due to _____

Duration

Other conditions (include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Sarah J. Rose

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Oliver Perry Rose 6. (c) Age of husband or wife if alive 100 years

7. Birth date of deceased August-9-1852
(Month) (Day) (Year)

8. AGE: Years 93 Months 3 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Andrew Co. (City, town, or county) (State or foreign country) mo

10. Usual occupation Housewife

11. Industry or business _____

12. Name John M. Stephens

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

14. Maiden name Mary Fiddler

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

16. (a) Informant Herman Rose

(b) Address Hempfle Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26-1945 (Month) (Day) (Year)

(c) Place: burial or cremation W.T. Jones

18. (a) Signature of funeral director H.T. Sullivan

(b) Address Esper mo

19. (a) 11-26-45 (Date received local registrar) (b) Mrs A C Hartel (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 J. C. Stearns (M. D. certifier)
Address Howar Mo Date signed 11-19-45

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

MOTHER FATHER

RECEIVED
District Health Officer No. 11,
District 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 W. A. Sullivan
Licensed Embalmer No. 1738
P. O. Address Gower 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.

Registration District No. 24

Primary Registration District No. 5298

1. PLACE OF DEATH:

(a) County Clinton

(b) City or town Rural Fayette
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarah J. Rose

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 9
(Month Day Year)

8. AGE: Years 93 Months 3 Days _____ If less than one day
hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1945 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 4-30-45
to _____, 19____, at _____, 19____,
that I last saw him _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Fractured long bone neck on 4-31-45 from a fall at his house

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

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Fall at his home

(b) Date of occurrence 4-30-1945

(c) Where did injury occur? Clinton Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in her country home
(Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature J. C. Sears (M. D. or other) _____
Address Lawson, Mo Date signed 12-25-45

SUPPLEMENTARY

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

MOTHER FATHER

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

36948

1952-1953
1954-1955
1956-1957
1958-1959
1960-1961
1962-1963
1964-1965
1966-1967
1968-1969
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2018-2019
2020-2021
2022-2023
2024-2025