

FILED DEC 15 1945 STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 157

Primary Registration District No. 4248

Registrar's No. 197

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Sarcoxie  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Life  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Georgia May Sabert

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

4. Sex f 5. Color or race W  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Henry  
6. (c) Age of husband or wife if alive dead years  
7. Birth date of deceased September 8, 1863  
(Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 0  
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name George S. Wilson  
13. Birthplace Charleston W. Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret J. Holman  
15. Birthplace Cannon Co., Tenn  
(City, town, or county) (State or foreign country)

16. (a) Informant Edison Sabert  
(b) Address Eldorado Kansas

17. (a) Burial (b) Date thereof 11/10/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sarcoxie Cemetery  
Roland Engelage

18. (a) Signature of funeral director Sarcoxie, Missouri  
(b) Address Sarcoxie, Missouri

19. (a) 11-13-45 (b) L. B. Clinton, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 8  
year 1945 hour 2 minute 00 AM/PM

21. I hereby certify that I attended the deceased from Nov 4  
1945 to Nov 8, 1945  
that I last saw her alive on Nov 7, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure Duration

Due to congestive heart failure  
arterial fibrillation

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

Major findings:  
Of operations 93.9  
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) .....

(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) (e) Means of injury

23. Signature J. E. Hillbane (M. D. or other) M.D.  
Address Sarcoxie Mo Date signed Nov 9 45

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

45-11-932

**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.....

*Geo B Orr*

Licensed Embalmer No.....

*946*

P. O. Address.....

*Mt Vernon 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.**