

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41356

State File No. _____

FILED JAN 11 1946

Registration District No. 171

Primary Registration District No. 3025

Registrar's No. 134

1. PLACE OF DEATH:

(a) County Howell
(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 at Residence
(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

3. (a) PRINT FULL NAME

Sarah E. Collins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F.

7 years

5. Color or race W

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

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

7. Birth date of deceased 2 (Month) 11 (Day) 1859 (Year)

8. AGE:

Years 86

Months 10

Days 1

If less than one day _____ hr. _____ min.

9. Birthplace

(City, town, or county)

Indiana (State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Joshua Hannah

13. Birthplace

(City, town, or county)

Indiana (State or foreign country)

14. Maiden name

Rebecca Street

15. Birthplace

(City, town, or county)

unk. a (State or foreign country)

16. (a) Informant

Mrs. J.W. Yocham

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

12-14-45 (Month) (Day) (Year)

(c) Place: burial or cremation

Union Grove

18. (a) Signature of funeral director

Robertson

(b) Address

West Plains, Mo.

19. (a)

Jan 4, 1946 (Date received local registrar)

(b) Blady Harrison (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howell
(c) City or town West Plains, Mo.
(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 12 day 12
year 1945 hour 6 minute 20 P.M.

21. I hereby certify that I attended the deceased from _____ 19____;
Had not seen doctor for _____ 19____;
that I last saw him over a year. _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death

Arteriosclerosis

Due to

Senility
Senility - Had not seen
Doctor in more than year.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy none

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

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence no
(c) Where did injury occur? no
(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 Blady Harrison (Registrar's signature)
Address West Plains, Mo. Date signed 1-4-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED.

District Health Officer No. 5,

District File Number

14672

Date Filed

11 11 46

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.....

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.