

U. S. No. 2
FORM-8-43
Rev. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27917

State File No. _____

FILED AUG 27 1946

Primary Registration District No. 6291

Registrar's No. 89

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

1. PLACE OF DEATH:

(a) County Ozark

(b) City or town Longrun 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 47 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Effie C. Sowards

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 married

6. (b) Name of husband or wife Leroy Sowards

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased September 12 1898
(Month) (Day) (Year)

8. AGE: Years 47 Months 10 Days 25
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name William Smith

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

14. Maiden name Julia C. Marritt

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

16. (a) Informant Lula Norton

(b) Address Jamesville, Mo

17. (a) Burial (b) Date thereof 8-13-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Longrun, Missouri

18. (a) Signature of funeral director Clint Lambert Funeral Home
(b) Address Gainesville, Mo

19. (a) 8-13-1946 (b) Mary E. Johnson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri Ozark 77

(a) State (b) County

(c) City or town Longrun-rural
(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 August day 7
year 1946 hour 5 minute 48 P. M.

21. I hereby certify that I attended the deceased from July 30 1946 to only 1946;
that I last saw her alive on July 30 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to _____

Due to _____

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

Major findings:
Of operations (30)

Of autopsy _____

Duration _____

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? _____

(a) Signature of person while at work? _____ (Specify type of place)

(c) Means of injury 0

23. Signature J. E. Searley (M. D. or other) _____
Address 1124 Mo Date signed 8.9.46

241

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District Number 846-876

Date Filed AUG 24 1946

AUG 24 1946

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. B. Hutchison

Licensed Embalmer No. 3737

P. O. Address Gainesville Tex

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.