

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Mo (b) County Carroll
(c) City or town Carrollton
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 6
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SARAH ANN WILSON
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife W E Wilson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar. 22 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 9 29 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Jacob Frety

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

14. Maiden name Susan Fleming

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

16. (a) Informant Clarence Wilson

(b) Address Carrollton Mo

17. (a) Burial (b) Date thereof 1-23-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Big Creek Cem

18. (a) Signature of funeral director Stanley Wilson

(b) Address Carrollton Mo

19. (a) 1/23/47 (b) Mr. Herbert Carter
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1947 hour 5 minute 150 M.
21. I hereby certify that I attended the deceased from October 1, 1946
to Jan 21, 1947
that I last saw her alive on January 20, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis + Myocardial degeneration
Duration Unknown

Due to _____

Due to _____

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

Major findings: _____
Of operations 930

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Ami H. Platy M.D. (M. D. or other) _____

Address Carrollton, Missouri Date signed 1-24-47

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 1-31-44

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.