

No. 2
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5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12066

State File No.

Registration District No. 322

Primary Registration District No. 6088

Registrar's No.

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall, Mo. "Rural"

(c) Name of hospital or institution:
R.F.D. 4
(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) All Her Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline ⁹⁷

(c) City or town Marshall "Rural" ⁰

(d) Street No. R.F.D. 4 (If rural, give location) ⁰

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Sarah Virginia Hendricks Price

3. (b) If veteran, name war #

3. (c) Social Security No. #

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, Widowed

6. (b) Name of husband or wife Joe H. Price

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

7. Birth date of deceased March 21, 1856
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>90</u>	<u>II</u>	<u>23</u>	hr. _____ min.

9. Birthplace Marshall R.F.D. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business !! !!

MOTHER FATHER

12. Name Robert J. Hendricks

13. Birthplace Buckingham Co. Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Virginia Ann Gaudin

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

16. (a) Informant Coleman Price

(b) Address Marshall, Mo. R.F.D. 4

17. (a) Burial (b) Date thereof 2/16/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Carmel Cemetery

18. (a) Signature of funeral director J. Fredic Sweeney

(b) Address Marshall, Mo.

19. (a) 2/17/47 (b) Mrs. Carl C. Muth
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14
year 47 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Feb 12, 1947, to Feb 14, 1947
that I last saw her alive on Feb 12, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Generalized Atherosclerosis

Due to _____

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

Major findings: 77A

Of operations _____

Of autopsy _____

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 _____ (a) Means of injury 0

23. Signature Jesse A. Reid M.D. (M. D. or other) 0

Address Marshall Mo Date signed 2/15/47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

292

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8

District File Number.....

Date Filed 3-21-47

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.....

J Leslie Surmacy

Licensed Embalmer No. 3235

P. O. Address. Marshall, 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.

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

State File No. April
Registrar's No. _____

Registration District No. 322

Primary Registration District No. 4472

1. PLACE OF DEATH:

(a) County Missouri
(b) City or town Missouri Town Rural
(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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Sarah V. H. Bruce

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 March 2
(Month) (Day) (Year)

8. AGE: Years 90 Months _____ Day _____ (if less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) Mr. Earl C. Metz (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 July Year 1944 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Due to _____
Due to _____

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

Major findings: Of operations _____
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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

12066