

S. No. 2
2-43
5-17-39

X33597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 10 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20773

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: West Plains Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 2 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 46
(c) City or town Pomona
(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 _____

3. (a) PRINT FULL NAME SARAH UDORA CAGE

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife John Calvin Cage 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 27, 1875
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name J. C. Williams
13. Birthplace Ill. (State or foreign country)
14. Maiden name Almyra Lough. (State or foreign country)
15. Birthplace Ill. (State or foreign country)

16. (a) Informant Mrs. Effie Shults
(b) Address Vinita, Okla.

17. (a) Mackey Cem. (b) Date thereof June 10, 1947
(Burial, cremation, etc.) (Month) (Day) (Year)
(c) Place: burial or cremation Howell Co., Mo. Dry Creek Twp.,

18. (a) Signature of funeral director Hal Thornburgh
(b) Address West Plains, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7,
year 1947 hour 12: minute 34 a. m.

21. I hereby certify that I attended the deceased from 2/6/5, 1947, to 6/7, 1947
that I last saw him alive on 6/7, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Sudden equal obstruction
Due to _____

Due to _____

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

Major findings: Of operations _____
Of autopsy _____
122 B

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) _____
(e) Means of injury _____

23. Signature Maurice Hauffman (M. D. or other) M.D.
Address West Plains, Mo. Date signed 6/11/47

Duration

PHYSICIAN

Underline the cause to which death should be attributed (initials)

ADDITIONAL INFORMATION REQUESTED

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

RECEIVED

District Health Officer No. 8

District File No. 797-358

Date Filed 7-8-47

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.....

S. L. Duncan

Registered Apprentice No. 390

working under my personal supervision.

Signed Hal Thomburg

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.

Registration District No. *141*

Primary Registration District No. *3025*

1. PLACE OF DEATH:

(a) County *Houell*
(b) City or town *West Plains*
(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 U. Cagle

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 _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years *72* Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) *7-16-1947* (b) *Beatrice Cook*
(Date received local registrar) (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 _____ Year *1947* Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to *No Autopsy so don't know*

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

Major findings: Of operations _____
Of autopsy *122B*

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 *Marion Thompson* (M.D. or other) *self*
Address *July 16 1947* Date signed

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

SUPPLEMENTARY

S-20773