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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 26 1947

Registration District No. 247

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21759

Primary Registration District No. 5839

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Newton

(b) City or town "Rural" Granby
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Route #1 Granby
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 42 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 7

(c) City or town "Rural" Granby
(If outside city or town limits, write "RURAL")

(d) Street No. Route #1
(If rural, give location)

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

If yes, name country X

3. (a) PRINT FULL NAME Rosie Belle SANDERS

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F

5. Color or race W.

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

6. (b) Name of husband or wife William L. Sanders

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased October (Month) 28 (Day) 1873 (Year)

8. AGE: Years 73 Months 7 Days 20 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name J. O. Jones
13. Birthplace Unknown (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Lizie Boswell
15. Birthplace Unknown (City, town, or county) Ill. (State or foreign country)

16. (a) Informant Mr. William L. Sanders
(b) Address Route #1 Granby, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (Month) 20 (Day) 47 (Year)
(c) Place: burial or cremation I.O.O.F. Cemetery Newtonia, Mo.

18. (a) Signature of funeral director Ed. C. Ulmer
(b) Address Carthage, Mo.

19. (a) 6-20-47 (Date received local registrar) (b) M. L. Young (Registrar's signature) 720

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18th.
year 1947 hour 4:30 minute P. M.

21. I hereby certify that I attended the deceased from about June 1st, 1947 to June 18, 19[illegible]
that I last saw her alive on on June 17, 19[illegible]
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia & resulting cardiac & renal failure due to same

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

10

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 John Langley (M. D.)
Address Box 93 [illegible] Mo. Date [illegible] 47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. [illegible]
District File Number 647-122
Date Filed 6-23-47

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 James C. Cleaver, Registered Apprentice No. 15, working under my personal supervision.

Signed Gene. C. Pugh.

Licensed Embalmer No. 4231

P. O. Address Carthage, 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, this should be so stated above.