

FILED JUL 24 1947

State File No. \_\_\_\_\_

Registration District No. 34

Primary Registration District No. 5117

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Rural Cedar  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Ashland R.F.D. 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 Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10  
(c) City or town Rural 5  
(If outside city or town limits, write "RURAL")  
(d) Street No. Ashland R.F.D. 0  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11  
year 1947 hour 4:00 PM minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from June  
1 1947 to July 11 1947  
that I last saw her alive on July 11 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death, Carcinoma of  
liver

Duration

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 46F  
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 0

23. Signature A. B. Bryant (M. D. or other)  
Address Ashland Mo Date signed 7-12-47

3. (a) PRINT FULL NAME Elizabeth E. Sapp  
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 Widowed  
6. (b) Name of husband or wife Harmer Sapp 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 15 1878  
(Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

12. Name James H. Nichols  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Amanda Peak  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Beulah White  
(b) Address Ashland, Mo.  
17. (a) Burial (b) Date thereof 7-13-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New Salem Cem.

18. (a) Signature of funeral director Wm D. Burnett  
(b) Address Ashland, Mo.

19. (a) 7-12-47 (b) Mrs Mildred Burnett  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number 720/47  
Date Filed 7/20/47

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 W. C. Burnett  
Licensed Embalmer No. 3564  
P. O. Address Ashtabula, W. Va.

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.