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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23808

FILED AUG 4 1947

Registration District No. 297

Primary Registration District No. 4165

Registrar's No. 76

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

1. PLACE OF DEATH:
(a) County Daviess
(b) City or town Gallatin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Own Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether)
In this community Most of Life
years, months or days

3. (a) PRINT FULL NAME Sarah Ann Greer
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (c) Age of husband or wife if alive Dec'd years
7. Birth date of deceased November 10 1858
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>8</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name William Rogers
13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Matilda Robertson
15. Birthplace Unknown North Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ethel Miller

(b) Address Gallatin, Mo.

17. (a) Burial (b) Date thereof 7-24-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brown Cemetery

18. (a) Signature of funeral director Hope Funeral Home

(b) Address Gallatin, Mo.

19. (a) 7-26-47 (b) W M Engelhart
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Daviess 31
(c) City or town Gallatin 1
(If outside city or town limits, write "RURAL") 0
(d) Street No. --- (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21
year 1947 hour 6 minute 30 P. M.

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

Immediate cause of death _____
Bell's Paralysis to head
Due to arterial plegmatization
(serile)

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.

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)
Means of injury g

23. Signature Frank E. Helms (M. D. or other)
Address Gallatin, Mo. Date signed 7/23/47

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *L. Dickerson*
Licensed Embalmer No. *23302*
P. O. Address *Gallatin 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.