

S. No. 2
4-8-43
5-17-39
K37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36851

State File No. _____

Registration District No. 354

Primary Registration District No. 4519

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Cabool
(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 6.2 yrs.
(Specify whether years, months or days)

In this community 6.2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Texas 107

(c) City or town Cabool 1
(If outside city or town limits, write "RURAL")

(d) Street No. _____ 0
(If rural, give location)

(e) Citizen of foreign country? _____ 0
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME MARGARET ANN SANKS

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 WIDOWED

6. (b) Name of husband or wife Edwin

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

7. Birth date of deceased Nov. 24 1854
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7 year 1947 11 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from Sept 7 1947 to Sept 7 1947 that I last saw her alive on Sept 7 1947 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>9</u>	<u>13</u>	hr. min.

Immediate cause of death Hypostatic Pneumonia 2 days

Due to Fracture of left hip 5 days

Due to _____

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

9. Birthplace Rolla Mo. 6
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name John Taylor

13. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Nannie Bradford

15. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Lever Sanks

(b) Address Cabool Mo.

17. (a) Burial (b) Date thereof Sept 30 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cabool

18. (a) Signature of funeral director Gaylord V. Elliott

(b) Address Cabool Mo.

19. (a) Sept 8 (b) Raynell Cunningham
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) _____ 107

(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 A. J. Brashe (M. D. or other) 2

Address Cabool, Mo Date signed 9/8/47

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 5,

District File Number 1047605

Date Filed 10-30-47

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 Gaylord V. Elliott
Licensed Embalmer No. 2252
P. O. Address Cabool

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.