



RECEIVED  
District Health Officer No. 9,  
District File No. 577  
AUG 31 1948

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.....  
Me.....  
working under my personal supervision.

Signed..... *Myford N. H. White*

Licensed Embalmer No..... 3838.....

P. O. Address..... Owensville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept  
Registrar's No. \_\_\_\_\_

Registration District No. 116 Primary Registration District No. 8020

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Washington  
(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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Mary M. Sassman

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 May 12 (Month) (Day) (Year)

8. AGE: Years 89 Months 3 Days 12 (If less than one day, hr. min.)

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

10. Usual occupation \_\_\_\_\_

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

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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 Aug Day 26 Year 1948 Hour \_\_\_\_\_ minute 11:30 P. M.

21. I hereby certify that I attended the deceased from Aug 14 to Aug 26, 1948 that I last saw her alive on Aug 26, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia Duration \_\_\_\_\_

Due to Fracture of femur

Due to Fall

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 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) Accident ✓

(b) Date of occurrence Aug 16, 1948 3:30 ✓

(c) Where did injury occur? Walden, Mo ✓ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? about home ✓

While at work? No (Specify type of place) (e) Means of injury Fall ✓

23. Signature J. M. M. M.D. (M. D. or other) Address Washington, Mo Date signed 9-8-48

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

SUPPLEMENTARY

5 25908 1948

Trading Co. Montreal 111 13,  
207  
Montreal 111 14