

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

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 28 1949

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. Hampton  
State File No. 42935  
Registrar's No. 7

Registration District No. 236

Primary Registration District No. 6131

1. PLACE OF DEATH:

(a) County Shannon  
(b) City or town Star Rt Mtn. View (Montevideo)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
In this community 78 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Shannon  
(c) City or town Star Rt Mtn. View  
(If outside city or town limits, write "RURAL")  
(d) Street No. DECEASED (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Sarah Effieann Foshe

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 \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 13 1870  
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Shannon Co Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER

12. Name William Smith  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Perhleece Woolsey  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Howard Foshe  
(b) Address Mountain View, Mo.

17. (a) Burial (b) Date thereof 11-2-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Side Cemetery

18. (a) Signature of funeral director Duncan Funeral Home  
(b) Address Mountain View, Mo

19. (a) 2-18-49 (b) H. S. Roane 306  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31  
year 1948 hour 5 minute 15 a.m.

21. I hereby certify that I attended the deceased from Aug 19 48 to OCT 31 19 48  
that I last saw him alive on OCT 31 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy  
Due to arterial hypertension  
Duration \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 830

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 fall

23. Signature Dr. Edwin Haugta (M. D. or other) Do  
Address Summersville Date signed Nov

RECEIVED 2-28-49  
District Health Officer No. 8  
District File Number 279.77  
Date filed 2-23-49

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 *Joe R. Duncan*  
Licensed Embalmer No. *4325*  
P. O. Address *Yonkers View, 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.**