

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 26 1949

5331 State File No. 15379

BIRTH NO. _____ REG. DIST. NO. 93 PRIMARY REG. DIST. NO. _____ Registrar's No. 32

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Dade | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY Dade | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL-Cedar Twp 1 | c. LENGTH OF STAY (in this place) Life | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL-Cedar Twp. 1 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Rt #2 Lockwood, Mo | | d. STREET ADDRESS (If rural, give location) Rt #2 Lockwood, Mo. | |

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|---|-------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) LENARD b. (Middle) JAMES c. (Last) SAWYERS | | | 4. DATE OF DEATH (Month) (Day) (Year) MAY 4 - 1949 | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH APR. 28, 1876 | | 9. AGE (In years last birthday) 73 <input type="checkbox"/> UNDER 1 YEAR 0 <input type="checkbox"/> UNDER 1 MONTH 6 <input type="checkbox"/> UNDER 1 HOUR 1 <input type="checkbox"/> UNDER 1 MIN. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer | | 10b. KIND OF BUSINESS OR INDUSTRY FARMING | | 11. BIRTHPLACE (State or foreign country) Missouri | |
| 13a. FATHER'S NAME Thomas C. Sawyers | | | 13b. MOTHER'S MAIDEN NAME MARY M. LOGAN | | 14. NAME OF HUSBAND OR WIFE MARY Belle SAWYERS |

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|--|-----------------------------------|---|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. No | 17. INFORMANT'S SIGNATURE OR NAME LOREN SAWYERS, Lockwood, Mo. ADDRESS _____ | | | |
|--|-----------------------------------|---|--|--|--|

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|--|--|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis | | | INTERVAL BETWEEN ONSET AND DEATH |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) pneumoniae lobae | | | 3 mo |
| | | DUE TO (c) _____ | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Valvular Heart | | | 490X |

| | | | | |
|--|--|---|---|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **8:30p m.**, from the causes and on the date stated above.

| | | | | |
|--|---|---|---|--------------------------------|
| 23a. SIGNATURE (Degree or title) G. B. Bannister M.D. (1) | | 23b. ADDRESS Price Spring Mo. | | 23c. DATE SIGNED 5-6-49 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE MAY 6 - 1949 | 24c. NAME OF CEMETERY OR CREMATORY Cedarville Cemetery | 24d. LOCATION (City, town, or county) (State) Cedar Twp. Dade Co. Mo | |
| DATE REC'D BY LOCAL REG. 5-11-49 | REGISTRAR'S SIGNATURE Geo. H. Weir | | 790 25. FUNERAL DIRECTOR'S SIGNATURE J. C. Canada ADDRESS Greenfield, Mo. | |

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

No. 300
10-48
29
0

RECEIVED

District Health Officer No. 6,

District File Number 549-575

Date Filed 5-23-49

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 _____

..... Student Embalmer No.
working under my personal supervision.

Signed
Student Embalmer

Signed

J. C. Canada

Licensed Embalmer No. 4196

P. O. Address Greenfield, 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.