

FILED AUG 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25960
State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>231</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rocksville</u>		c. LENGTH OF STAY (in this place) <u>7 1/2 mo's</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rocksville</u>		d. STREET ADDRESS (If rural, give location) <u>1103 East Harrison</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sarah</u>		b. (Middle) <u>(None)</u>		c. (Last) <u>Gilfillin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 5 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>Oct 11, 1862</u>	
9. AGE (in years last birthday) <u>87</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millinery Store</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Litchfield, Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Hosp. records</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Medullary Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebellar Anemia</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>unknown</u> <u>4500</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		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 <u>10/5/1948</u> to <u>8/5/1949</u> , that I last saw the deceased alive on <u>August 5, 1949</u> , and that death occurred at <u>4:15 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>M.T. Gutensohn D.O.</u>		23b. ADDRESS <u>Rocksville, Mo.</u>		23c. DATE SIGNED <u>8-8-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Aug 6, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hewellyn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Rocksville, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-9-49</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. Harris</u>			
				ADDRESS <u>Rocksville</u>			

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

(Licensed Embalmer's Statement on Reverse Side)

AUG 15 1949

RECEIVED

District Health Officer No. 10

District File Number 8-49-1711

Date Filed AUG 16 1949

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.

Student
Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirksville, 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.