

THE DIVISION OF HEALTH OF MASSACHUSETTS
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILE SEP 9 1949

BIRTH NO. _____		REG. DIST. NO. <u>107</u>		PRIMARY REG. DIST. NO. <u>3019</u>		Registrar's No. <u>106</u>	
1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Dunklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kennett</u>		c. LENGTH OF STAY (In this place) <u>38 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kennett</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>709 N. Main Street</u>				d. STREET ADDRESS (If rural, give location) <u>709 N. Main Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sarah</u>			b. (Middle) <u>—</u>		c. (Last) <u>Sneed</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 1-1949</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Unmarried</u>		8. DATE OF BIRTH <u>Jan 31-1881</u>		9. AGE (In years) (Months) (Days) (Hours) (Min.) <u>68</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Malden Mo. D</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Garforth</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Herbert Caden Kennett Mo.</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>Cancer of Uterus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>194X</u>	
19a. DATE OF OPERATION <u>1-15-1949</u>		19b. MAJOR FINDINGS OF OPERATION <u>Small uterine cancer</u>				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>June 15, 1949</u> to <u>Aug 31, 1949</u> , that I last saw the deceased alive on <u>Aug 31, 1949</u> , and that death occurred at <u>2:30 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Robert S. Green M.D.</u>				23b. ADDRESS <u>Kennett Mo.</u>		23c. DATE SIGNED <u>9-2-1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-2-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Malden</u>		24d. LOCATION (City, town, or county) (State) <u>Malden Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-2-1949</u>		REGISTRAR'S SIGNATURE <u>Carl Schubert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leitch Service</u>		ADDRESS <u>Kennett Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

SEP 6 19

District Health Office No. 2

District File Number 944-87

Date Filed

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

Signed Student Embalmer

Licensed Embalmer No.

P. O. Address

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.