

FILED MAR 2 - 1953

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **6689**

BIRTH NO. _____ REG. DIST. NO. **174** PRIMARY REG. DIST. NO. **3035** Registrar's No. **29**

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If migration: residence before death.) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, write RURAL and give township) Lexington		c. CITY (If outside corporate limits, write RURAL and give township) Waverly	
c. LENGTH OF STAY (In this place) 5 days		d. STREET ADDRESS (If rural, give location) 2 block north 24 highway	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lexington Memorial			
3. NAME OF DECEASED (Type or Print) Sarah Elizabeth Rea		4. DATE OF DEATH (Month) (Day) (Year) Feb 21 1953 - 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 16, 1877
9. AGE (In years) (Months) (Days) (Hours) (Min.) 75 10-5		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Buffalo, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John Thomas Skaggs		13b. MOTHER'S MAIDEN NAME Nancy Barkley	
14. NAME OF HUSBAND OR WIFE A.S. Rea			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME A.S. Rea		ADDRESS Waverly Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetic Coma		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis Sclerosis Tuberculosis	
19a. DATE OF OPERATION Feb 18-1953		19b. MAJOR FINDINGS OF OPERATION Fracture hip - operated	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Fracture hip		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Fell at home	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Waverly 154 Lafayette Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 16 1953		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? Fell at home			
22. I hereby certify that I attended the deceased from Feb 16, 1953 , to Feb 21, 1953 , that I last saw the deceased alive on Feb 20, 1953 , and that death occurred at 12:03 PM , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Ben H. Brasher MD		23b. ADDRESS Lexington Mo	
23c. DATE SIGNED 2/22/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-21-53	
24c. NAME OF CEMETERY OR CREMATORY Waverly Cemetery		24d. LOCATION (City, town, or county) (State) Waverly Mo	
DATE REC'D BY LOCAL REG. 2-27-53		REGISTRAR'S SIGNATURE Wm. E. Eastabrook	
25. FUNERAL DIRECTOR'S SIGNATURE Marshall Funeral Home		ADDRESS Correllton Mo	

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

05420

MAR 11 1959

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

R. M. Marshall Jr.

Licensed Embalmer No. *4469*

P. O. Address *Carrollton, 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.