

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000610

STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 11 Primary Registration District No. 3012 Registrar's No. 8

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY CLAY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CLAY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN EXCELSIOR SPRINGS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN EXCELSIOR SPRINGS | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION EX. SPRINGS HOSP. LIFETIME | | | Length of stay in 1b | | | d. STREET ADDRESS 3 mi. S. EX. SPRS. | |
| 3. NAME OF DECEASED (Type or print) SARAH ELIZABETH SNOW | | | | 4. DATE OF DEATH Month JAN. Day 13 Year 1959 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-23-1872 | |
| 9. AGE (In years last birthday) 86 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (City and state or country) CLAY CO. MO. O. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME JAMES MOORE | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 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. NONE | | 17. INFORMANT Address AMBROSE SNOW, Rt #2, Ex. Spas Mo. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Intestinal Obstruction and Hemorrhage from intestinal tract Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of Sigmoid DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hours unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Failure & Pulmonary edema 1533 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour 11:30 a. m. p. m. Month, Day, Year | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from 12/29/1958 to 1/13/59 and last saw her ^{her} deceased alive on 1/13/59 Death occurred at 11:30 p. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Ralph L. Nicholson, M.D. | | | | 22b. ADDRESS Excelsior Springs, Mo. | | 22c. DATE SIGNED 1/14/59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 1-15-59 | | 23c. NAME OF CEMETERY OR CREMATORY CROWN HILL | | 23d. LOCATION (City, town, or county) (State) EXCELSIOR SPRINGS Mo. | |
| 24. FUNERAL DIRECTOR Prichard Funeral Home, Inc. Excelsior Springs, Missouri | | | 25. DATE RECD. BY LOCAL REG. 1-26-59 | | 26. REGISTRAR'S SIGNATURE Baroline Hutchings | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by Student Embalmer No. working under my personal supervision..

Student..... Signature of Student Embalmer

Signed *Smilee Jarna*.....

Licensed Embalmer No. *49*
Excelsior Springs
P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.