

REC'D APR 21 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

11409  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Macon Registration District No. 535  
(b) Township Narrows Primary Registration District No. 5720 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Sarah Ann Gilbert 416  
(a) Residence, No. Farm - Macon county St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED WIFE OF William B. Gilbert  
6. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 14, 1847  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
90 11 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Huddersfield England

FATHER 13. NAME John Farrar England  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Salina Thorn ton  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Mrs. Ella M, Demick Macon

18. BURIAL, CREMATION, OR REMOVAL PLACE Macon - Oakwood DATE March 11 38

19. FUNERAL DIRECTOR (ADDRESS) Albert Skinner Macon, Mo

20. FILED 19. \_\_\_\_\_ Local Registrar. 478

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 9, 1938

22. I HEREBY CERTIFY, That I attended deceased from 1/19/38, 1938, to 3/9, 1938  
I last saw her alive on 1/19/38, 1938. Death is said to have occurred on the date stated above, at 1:30 A.M.  
The principal cause of death and related causes of importance were as follows:

Senile Myocarditis  
Angina of heart  
Date of onset 3

Other contributory causes of importance: None

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify Howard Miller, M. D.  
(Signed) Macon, Mo (Address) 478

9301-

MAY 14 1947

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
DIVISION OF ANATOMY  
SAN FRANCISCO, CALIF.

STATEMENT BY LICENSED EMBALMER

I, Russell Barber, Licensed Embalmer No. 3848

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Russell W Barber

Licensed Embalmer No. 3848

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.)

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

(a) County Macon Registration District No. \_\_\_\_\_  
 (b) Township \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah a. Gilbert

(a) Residence, No. \_\_\_\_\_ St.  \_\_\_\_\_ (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
90 11 25

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_, 19\_\_\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 9, 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Myocarditis  
Stenosis of toes  
(Eudartinitis)  
 Other contributory causes of importance:

Date of onset

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Howard Miller, M. D.

(Address) Macon

REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

C. REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

