

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

2848  
Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 467  
 (b) Township Aurora Primary Registration District No. 4280 Registered No. \_\_\_\_\_  
 (c) City Aurora (d) Street No. 824 Porter Ave 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 B Woodhall

(a) Residence, No. 824 Porter Ave 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 HUSBAND OF (OR) WIFE OF John Woodhall  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 24-1862  
 7. AGE YEARS 76 MONTHS 0 DAYS 25 If LESS than 1 day, .....hra. or .....min.  
 OCCUPATION 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) Iowa

FATHER 13. NAME John Brown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Terre Haute Indiana

MOTHER 15. MAIDEN NAME Susan Brooks

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

17. INFORMANT Guy Harvey (ADDRESS) Baxter Springs Kansas

18. BURIAL, CREMATION, OR REMOVAL PLACE Aurora Mo. DATE Jan 21, 1935

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. P. King Aurora Mo.

20. FILED Jan. 22, 1935 J. P. Cowan, Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan, 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from 11-11H, 1938 to 1-18-, 1939  
 I last saw h. ex. alive on 1-18-, 1939 Death is said to have occurred on the date stated above, at 8.25P.M.

The principal cause of death and related causes of importance were as follows:  
Arterial Sclerosis + Cardiac Dilatation Date of onset \_\_\_\_\_

Other contributory causes of importance: Heart failure 1935  
Spontaneous asphyxia  
11-11H-1935

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Physical 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 \_\_\_\_\_  
 (Signed) J. P. Cowan, Jr. M. D.  
 (Address) Aurora, Mo.

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Herman M. J. ...*

Licensed Embalmer No. 3072.....

P. O. Address. AURORA Mo. ....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**