

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

16367
Do not use this space.

1. PLACE OF DEATH
 (a) County Fernon Registration District No. 875
 (b) Township Center Primary Registration District No. 3039 Registered No. 105
 or Nevada (c) City Nevada (d) Street No. 404 N. Washington 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 AMANDA CLINE
 (a) Residence, No. 404 N. Washington 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 Not known

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 14 - 1845

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>93</u>	<u>25</u>	<u>17</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housekeeper

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) Shelby Ohio

FATHER

13. NAME Mass

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

MOTHER

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Roy Cline

18. BURIAL, CREMATION, OR REMOVAL PLACE Cathay DATE Apr. 16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Free Mortuary
Cathay

20. FILED 4-20 1939 Allen E. Hays Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 16 1939

22. I HEREBY CERTIFY, That I attended deceased from April 2 1939, to April 16 1939
 I last saw her alive on April 12 1939. Death is said to have occurred on the date stated above, at 2:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage Date of onset

Other contributory causes of importance: g.f.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

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) [Signature], M. D.
 (Address) Nevada, Mo.

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.

RECEIVED

District Health Officer No.

District File Number 7-39-13

Date Filed 5-8-39

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. ~~397~~

working under my personal supervision.

Signed Emm. L. Hall

Licensed Embalmer No. 391

P. O. Address Carthage

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

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