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

REC'D JUL 13 1939

23429
Do not use this space.

1. PLACE OF DEATH
(a) County Stoddard
(b) Township Center
(c) or City Bloomfield
Registration District No. 837
Primary Registration District No. 4508
Registered No.
(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 J. Bess
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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.

10-4-0

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-16-1870
7. AGE Years 69 Months 2 Days — If LESS than 1 day, ...hrs. 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) Mo.

FATHER
13. NAME Marshall Willis
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N.C.

MOTHER
15. MAIDEN NAME Charity Elizabeth Barton
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. C.

17. INFORMANT (ADDRESS) Carrie L. Aslin, Bloomfield, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Walkers Cem. DATE June 18, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chiles Und. Co., Bloomfield, Mo.
20. FILED June 20, 1939 Boonie Punch Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-16-1939

22. I HEREBY CERTIFY, That I attended deceased from June 10-, 1939, to June 16, 1939
I last saw her alive on June 15, 1939 Death is said to have occurred on the date stated above, at 4:30 A. m.
The principal cause of death and related causes of importance were as follows:

Double Lobar Pneumonia — Date of onset 10 8

Other contributory causes of importance:
Chronic Bronchitis following Flu 1935

Name of operation None Date of
What test confirmed diagnosis? C 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) S. S. Glass, M. D.
(Address) Desloge Mo

895

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2,
District File Number 739-39
Date Filed 2-41

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 Lulu A. Cooper, Registered Apprentice No. 162 working under my personal supervision.

Signed Lulu Cooper

Licensed Embalmer No. 3499

P. O. Address Bloomfield, Mo.

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

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