

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

JAN 15 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42608

Registration District No. 11

Primary Registration District No. 5015

Registrar's No. 25

1. PLACE OF DEATH:  
(a) County Andrew  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: Rural Jackson Township  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 60 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Andrew  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural Jackson Township  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME SARAH ELIZABETH HART  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 12 day 14  
year 1939 hour 4 minute 20 A. M.  
21. I hereby certify that I attended the deceased from April 8  
1936 to Dec -12 1939  
that I last saw her alive on 12 - 8 1939  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow  
6. (b) Name of husband or wife James Abram Hart 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 5 23 1862  
(Month) (Day) (Year)

Immediate cause of death Myocarditis Chronic No Facts  
Stroke Debility  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 77 Months 6 Days 21  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy None

9. Birthplace Andrew county mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation at home

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

MOTHER FATHER  
12. Name Louis Wright  
13. Birthplace un known ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Martha Shunk  
15. Birthplace un known mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Amos Hart  
(b) Address Fillmore mo  
17. (a) Burial (b) Date thereof 12-15-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Fillmore  
18. (a) Signature of federal director E. G. Breit  
(b) Address Savannah mo 11  
19. (a) Dec. 15, 39 (b) Wm. Addie Barnes  
(Date received local registrar) (Registrar's signature)

23. Signature M. L. Holiday (M. D. or other) M. D.  
Address Fillmore mo Date signed 12-14-39

RECEIVED

District Health Office No. 111

District File No.

140 - 1874

Date Filed

JAN-11-1949

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 *me*

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*E. C. Breit*

Licensed Embalmer No. *2650*

P. O. Address *Savannah mo*

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.)

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