DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44754

Registration District No. _____ Primary Registration District No. 795 Registrar's No. 69

1. PLACE OF DEATH:
(a) County: Saline
(b) City or town: Malta Bend (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____ (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ In this community 20 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Saline
(c) City or town: Malta Bend Mo (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME: SARAH B. GORMAN
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex: Fe
5. Color or race: W
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Harry A Gorman
6. (c) Age of husband or wife if alive: 69 years
7. Birth date of deceased: Jan (Month) 26 (Day) 1874 (Year)

8. AGE: Years 65 Months 10 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace: Carroll (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Home-wife
11. Industry or business: /
MOTHER FATHER
12. Name: Elihu Quillin
13. Birthplace: Ohio (City, town, or county) (State or foreign country)
14. Maiden name: Malinda Barnett
15. Birthplace: K. N. (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: G M Gorman
(b) Address: Grand Pass Mo
17. (a) _____ (Burial, cremation, or removal) (b) Date thereof 12-17-1939 (Month) (Day) (Year)
(c) Place: burial or cremation: Carrollton Mo
18. (a) Signature of funeral director: Harry Hershberger
(b) Address: Marshall Mo
19. (a) 12-16-39 (Date received local registrar) (b) Raymond Spencer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15 year 1939 hour 9:10 minute P M.
21. I hereby certify that I attended the deceased from Dec 13, 1939, to Dec 15, 1939; that I last saw her alive on Dec 15, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Osteosarcoma	9 yrs.
Due to:	
Other conditions: None (Include pregnancy within 3 months of death)	
Major findings: Of operations: None	
Of autopsy: None	

PHYSICIAN — Underline the cause to which death should be charged statistically

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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature: Harry B. Cozad (M.D. or other) DO.
Address: Malta Bend, Mo. Date signed 12/16/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 6-17-39

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1/10/40

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 Fred Wilkinson

Licensed Embalmer No. 2478

P. O. Address Clinton 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.