

FILED FEB 15 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH2200
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 24
 (b) Township Smiley Primary Registration District No. 5575 Registered No. _____
 or _____
 (c) City _____ (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Sarah Lucinda Hoyle 400
 (a) Residence, No. Dallas, Mo. 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 <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Simon Hoyle</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1-22-1899</u>		
7. AGE	YEARS <u>41</u>	MONTHS <u>3</u>
	DAYS <u>3</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housekeeper</u>	
	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) <u>Mo.</u>		
FATHER	13. NAME <u>Johnston Bradley</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
MOTHER	15. MAIDEN NAME <u>Polly Skaggs</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
17. INFORMANT (ADDRESS) <u>Martha Webster</u> <u>Belt, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>A. B. Cemetery</u> DATE <u>1-27-40</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. B. Jones</u> <u>Buffalo Mo.</u>		
20. FILED <u>Jan. 31</u> 19 <u>40</u> <u>W. M. Stogodill</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-25 1940

22. I HEREBY CERTIFY, That I attended deceased from 1/16 1940 to 1/25 1940
 I last saw her alive on 1/23 1940 Death is said to have occurred on the date stated above, at 6 P. m.
 The principal cause of death and related causes of importance were as follows:
Tuberculosis of lungs
 Date of onset 1925

Other contributory causes of importance:

Name of operation P. X. P. 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? _____
 If so, specify _____
 (Signed) L. A. Hines M. D.
851 (Address) W. B. Jones

RECEIVED
District Health Officer No. 7,
District File Number 2-40-227
Date Filed 2-13-40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.