

Registration District No. 992

Primary Registration District No. 5027

Registrar's No. 992

1. PLACE OF DEATH:
(a) County Barry
(b) City or town Rural, Ozark Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
(years, months or days)

3. (a) PRINT FULL NAME Sarah Jane Samuels 542
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife H.P. Samuels 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 31 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
12. Name Pete Richardson
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Ella Bunest
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. J. King
(b) Address Aurora Mo.

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Leann Cemetery

18. (a) Signature of funeral director J. J. King
(b) Address Aurora Mo.

19. (a) March 14 (b) Don Brechbuler
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19
year 1940 hour 11 minute 30A. M.
21. I hereby certify that I attended the deceased from Jan 20 40
Feb 11, 1940, to Feb 11, 1940;
that I last saw her alive on Feb 5, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration Feb. 40
hem. phlegm stroke
Due to hypertension 2
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature Frank Rye MD (M. D. or other) _____
Address Monett Mo Date signed 3/14/40

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.

RECEIVED

District Health Officer No. 6,

District File Number 3210-645

Date Filed MAR 5 1940

82A

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.....

Not Embalmed....., 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5810

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 992

Primary Registration District No. 5047

Registrar's No. 992

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Oparka, Mo
(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 _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME

Sarah Jane Samuels

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace. (City, town, or county) (State or foreign country)

MOTHER FATHER

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace. (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof. (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 19 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction with hypertension
Due to Myocardial infarction due to
Due to Cerebral hemorrhage

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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 Frank Kess (M. D. or other) _____
Address Monett, Mo Date signed _____

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

SUPPLEMENTAL

S-5810