

Registration District No. 398

Primary Registration District No. 3019

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
520 West College
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME Sarah Carter French

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Fe 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased January 10, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 1 6 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name Richard Lillard
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Katie
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant John R. Franklin
(b) Address 520 West College

17. (a) Burial (b) Date thereof 2/21/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cem.

18. (a) Signature of funeral director J. L. Cook
(b) Address 1729 Lydia

19. (a) Feb 19/40 (b) J. L. Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 520 West College
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16
year 1940 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from Jan 1939
to Feb 16, 1940, 19____; that I last saw her alive on 7/16/40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension Chronic
nephritis & Chronic
Due to Myocarditis

Other conditions (Include pregnancy within 3 months of death)

Major findings: 131
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)
(e) Means of injury _____

23. Signature F. L. Cook (M. D. or other) _____
Address Independence Date signed 2/19/40

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

4854

FILED MAR 1940

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 T. P. Perkins

Licensed Embalmer No. 2889

P. O. Address 1729 Hudson

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.