

FILED MAR 5 - 1940
429

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7078

Registration District No. 429

Primary Registration District No. 429

Registrar's No.

51
4
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Knob Noster Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Johnson
(c) City or town Knob Noster 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.

In this community _____ years, months or days

MEDICAL CERTIFICATION

3. (a) PRIN FULL NAME Sarah Matilda Bell

20. DATE OF DEATH: Month Feb day 10
year 1940 hour 4:30 minute _____ M.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

21. I hereby certify that I attended the deceased from Feb 10, 1940 to Feb 10, 1940
that I last saw her alive on Feb 10, 1940
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

Immediate cause of death: Chc Valvular disease

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

7. Birth date of deceased Sept 20 1860
(Month) (Day) (Year)

Due to _____
Due to _____

8. AGE: Years 79 Months 5 Days 20 If less than one day _____ hr. _____ min.

Other conditions: Chc Pulmonary T.B.
(Include pregnancy within 3 months of death)

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

Major findings: Of operations _____

10. Usual occupation Housewife

Of autopsy no

11. Industry or business _____

12. Name: Newton Shaw

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

14. Maiden name Rachael West

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

16. (a) Informant John Bell

(b) Address Knob Noster Mo

17. (a) Burial (b) Date thereof Feb-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Knob Noster Mo

18. (a) Signature of funeral director C. J. Sauls

(b) Address Knob Noster Mo

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

22. If death was due to external causes, fill in the following: no

(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 H. W. Throve (M. D. or other) _____
Address Knob Noster Mo Date signed Feb 12

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Dudley R. Sauls

Registered Apprentice No. *249*

working under my personal supervision.

Signed

C. L. Sauls

Licensed Embalmer No. *1086*

P. O. Address *Knob Hostis M.*

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.