

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

7597  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Oregon Registration District No. 634  
 (b) Township Geokel Primary Registration District No. 5841 Registered No. 4  
 (c) City \_\_\_\_\_ (d) Street No. 27 Home 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

SARAH JANE HOLLIS  
 (a) Residence, No. Alton Mo. P. 2 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 Female  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. W. Hollis  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jun 14 1875  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
64      11      19  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife  
 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 44

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 2 1940  
 22. I HEREBY CERTIFY, That I attended deceased from Jan. 2 1940, to Jan. 2 1940  
 I last saw her alive on Jan. 2 1940. Death is said to have occurred on the date stated above, at 8 o'clock P. m.  
 The principal cause of death and related causes of importance were as follows:

Hemiplegia  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oregon Co. Mo.

FATHER 13. NAME Wm. Cousin

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Sarah Jane Cousin

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oregon Co Mo.

17. INFORMANT (ADDRESS) i

18. BURIAL, CREMATION, OR REMOVAL PLACE Hollis Cemetery Jan 3 1940

19. FUNERAL DIRECTOR (ADDRESS) Family

20. FILED 2/28 1940 Convek Bailey Local Registrar.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no 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. at home  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) W. H. Wilson M. D.  
 (Address) Alton Mo.

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.

52A

RECEIVED

District Health Officer No. 5,

District File Number 340 269

Date Filed 3 8 4 0

STATEMENT BY LICENSED EMBALMER

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_

hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_

\_\_\_\_\_ L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.)

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **7597**

Registration District No. **636**

Primary Registration District No. **5841**

Registrar's No. **4**

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

1. PLACE OF DEATH:

(a) County: **Oregon**

(b) City or town: **Beard**  
(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 Hollis**

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: **m**

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 **64** Months **11** Days **19** If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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.

20. DATE OF DEATH: Month **Jan** day **2**  
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: **Hemiplegia**

Due to: **was this Hemiplegia seen due cerebral hemorrhage**

Due to: **Just what part of the brain this hemorrhage**

Other conditions: **Accid & do not know**  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: **g2w**

Of autopsy: \_\_\_\_\_

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: **S. N. Helton** (M. D. or other)

Address: **Alton Mo** Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

