

MAY 15 1940

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

15292
Do not use this space.

1. PLACE OF DEATH
 (a) County Laclede Registration District No. 449
 (b) Township Washington Primary Registration District No. 5612
 (c) City or Street No. _____
 (d) Street No. _____ (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 Montgomery
 (a) Residence, No. Lebanon Mo. Newark (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chas. Montgomery
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 1872
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
67 4 0
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 4 1940
 22. I HEREBY CERTIFY, That I attended deceased from 7-1, 1939 to 4-4, 1940
 I last saw her alive on 3-6, 1940. Death is said to have occurred on the date stated above, at 7:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Hypertensive Heart Disease
 Date of onset _____
 Other contributory causes of importance:
Emphysema Left - Wreid
 Name of operation _____ 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 Paul A. Perkins, M. D.
 (Signed) _____
J. H. Montgomery, Missouri
 (Address) _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dallas Co Mo
 13. NAME Franklin Russell
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know
 15. MAIDEN NAME Mary Baker
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know
 17. INFORMANT (ADDRESS) Chas. Montgomery
Lebanon Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Zion DATE 4/5/40
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W.E. Holman
Lebanon Mo
 20. FILED 4-5 1940
 Local Registrar.

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

95132

RECEIVED

District Health Officer No. 7,

District File Number 5-40-812

Date Filed 5-8-21

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.

myself

Signed..... *W.E. Halman*

Licensed Embalmer No. *4107*

P. O. Address *Lebanon Mo*

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. 15292

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 449

Primary Registration District No. 5612

Registrar's No. _____

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

PM

1. PLACE OF DEATH:

(a) County Laclede
(b) City Washington T.P.
(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) (Specify whether

3. (a) PRINT FULL NAME Sarah Jane Montgomery

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

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 67 Months 4 Days 0 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(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 Apr day 4
year 1946 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 Hypertension
Heart Disease
Due to Cerebral hemorrhage

Due to 95 B²

Other conditions hemiplegia left
(Include pregnancy within 3 months of death)

Major findings: meninges - one
Of operations: to hemorrhage
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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

