

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18910**

Registration District No. **497**

Primary Registration District No. **5672**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County **Linn**
 (b) City or town **North Salem Township**
 (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) **2**
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community **Seven years**
 years, months or days)

8. (a) PRINT FULL NAME **Sarah Catherine Dorothy**

8. (b) If veteran, name war **V** 8. (c) Social Security No. **V**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Sherman N. Dorothy** 6. (c) Age of husband or wife if alive **74** years

7. Birth date of deceased **March 23, 1878**
 (Month) (Day)

8. AGE: Years **76** Months **21** Days **26** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Joseph Conn**

18. Birthplace **Don't know Ohio**
 (City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Tavever**

15. Birthplace **Don't know Ohio**
 (City, town, or county) (State or foreign country)

16. (a) Informant **S. N. Dorothy**

(b) Address **North Salem**

17. (a) **Burial** (b) Date thereof **May 22, 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Brookfield, Mo. Rose Hill Ceme.**

18. (a) Signature of general director **Bliss E. Kent**

(b) Address **Green City, Mo. 441**

19. (a) **May 20, 1940** (b) **Wm. R. Williams**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Linn**
 (c) City or town **Rural**
 (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 **May** day **19**
 year **1940** hour **10** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **December 15, 1939, to June May 19, 1940,**
 that I last saw her alive on **May 16, 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Arteriosclerotic gangrene of left leg** Duration **7/39**

Due to _____

Due to _____ **40**

Other conditions **Semility**
 (Include pregnancy within 3 months of death)
Cervix 7 Cervix

Major findings: Of operations _____

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 **J. R. McArthur** (M. D. or other) **1**

Address **Brookfield Mo** Date signed **May 20/40**

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

RECEIVED

District Health Officer No. 11,

District File Number 640-932

Date Filed JUN 13 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

Archie W. Wade

Licensed Embalmer No.

3037

P.O. Address:

Green City

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.

North Salem Mo - July 5 - 1940
Mrs Lila Williams

Browning Mo.

Dear Madam,

Your card of recent date
received,

The date of my wife's birth,
Sarah Edith Dorothea,
was March 23, 1864.

She was 76 yrs, 1-month, 26 days

Very Respectfully,

S. N. Dorothy.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18910

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 497

Primary Registration District No. 2672

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Salmon
(b) City or town Salmon 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)

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.

3. (a) PRINT FULL NAME

Sarah Catherine Dorothy

(b) If veteran, name war _____

(c) Social Security No. _____

5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

4. Sex _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife, if alive _____ year

7. Birth date of deceased _____

(Mar - 23 - 1864)
(Month) (Day) (Year)

8. AGE:

Years 76 Months 1 Days 26

If less than one day _____ hr. _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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) _____

Mar 31 1940
(Date received by registrar)

Ms. Lila Williams
(Registrar's signature)

MEDICAL CERTIFICATION

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

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

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

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)
(Type of team of injury)

23. Signature T.R. McArter (M. D. or other)

Address Browning State signed _____

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

SUPPLEMENTAL

10/17