PARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22114

1940 JUL 17 PM

...tration District No. 465 Primary Registration District No. 4278 Registrar's No. 58

...ACE OF DEATH:

(a) County Lafayette

(b) City or town Waverly
(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 2 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Waverly
(If outside city or town limits, write "RURAL")

(d) Street No. D
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ... years.

3. (a) PRINT FULL NAME SARAH DANIELS 542

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Logan Daniels

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

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years Unknown Months Unknown Days 0 If less than one day ... hr. ✓ min.
Very aged

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

10. Usual occupation Housewife

11. Industry or business None 9

MOTHER FATHER
12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Maria Miles
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature David Brooks
(b) Address Waverly Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Waverly Mo

18. (a) Signature of funeral director T. T. Ferguson
(b) Address Marshall Mo

19. (a) June 30 - 1948 (Date received local registrar) (b) Clayton W. Landrum (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26 year 1940 hour 11:00 minute P M.

21. I hereby certify that I attended the deceased from Dec. 20, 1939 to June 26, 1940; that I last saw her alive on June 24, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
cardio-vascular-renal disease	?
Due to	
Due to	
Other conditions none (Include pregnancy within 3 months of death)	

Major findings:
Of operations no operation
Of autopsy no 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Geo. A. Kelling, M. D. (M. D. or other) M.D.
Address Waverly, Mo. Date signed 6/27/40

(Licensed Embalmer's Statement on Reverse Side)

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 ver

RECEIVED
District Health Officer No. 8
Death File Number 7-16-40
Date Filed

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~~ F. D. Ferguson, Registered Apprentice No. ..... working under my personal supervision.

Signed F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Marshall M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

. 2B
21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22 114

Registration District No. 465 Primary Registration District No. 4278 Registrar's No.

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Lexington
(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 years, months or days)
In this community

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 Daniels
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race Negro
6. (a) Single, widowed, married, divorced widow
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 95 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Aug. 6-26-1940 (Date received local registrar) (b) Clayton H. Landrum (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26 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 — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
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? (Specify type of place)
While at work (e) Means of injury
23. Signature Geo. A. Kelling (M. D. or other)
Address Waverly Mo. Date signed

SUPPLEMENTARY