

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

REV. 8-17-39 I X1511

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32478

Registration District No. 508 Primary Registration District No. 3026

Registrar's No. 127

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chillicothe
(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 20
(Specify whether
In this community 60 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston
(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. 422 Vine St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Nannie A. Sawyer

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

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

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

7. Birth date of deceased December 6, 1852
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>9</u>	<u>20</u>	<u>✓</u> hr. <u>✓</u> min.

9. Birthplace Frankfort K.Y.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Dr. Thomas F. Owen

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

14. Maiden name Malinda Batts

15. Birthplace _____ K.Y.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lee Sawyer

(b) Address Chillicothe Mo.

17. (a) Burial (b) Date thereof 9/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edgewood

18. (a) Signature of funeral director James Gordon

(b) Address Chillicothe Mo.

19. (a) 9-28-40 (b) A. M. Wallace, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1940 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from 9-17-40, to 9-26-40
that I last saw her alive on 9-26-1940, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of right hip -
Due to _____
Due to _____

Other conditions Vascular Hypertension
(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) Accident

(b) Date of occurrence 9-17-1940

(c) Where did injury occur? Chillicothe Livingston
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Her hair in stairs
While at work? Long hair in stairs
(Type of place) (e) Means of injury fall

23. Signature P. R. K. Barnell (M. D. or other)

Address Chillicothe Mo. Date signed 9-28-40

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.....

Donald F. Gordon....., Registered Apprentice No. 223
working under my personal supervision.

Signed.....

James D. Gordon
.....

Licensed Embalmer No. 1870

P. O. Address Chullicotho, N

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.