

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32642

Registration District No. 55

Primary Registration District No. 4033

Registrar's No. 47

1. PLACE OF DEATH

(a) County Wagon
(b) City or town Wagon
(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
In this community 34 years
years, months or days)

3. (a) PRINT

FULL NAME SARAH CHRISTINE ATCHLEY

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 married

6. (b) Name of husband or wife Wm. Atchley

6. (c) Age of husband or wife if

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

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

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) (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)

(Date received local registrar)

(Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County New Madrid
(c) City or town Wagon
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

3. DATE OF DEATH: Month Oct day 1
year 1940 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from Oct 1, 1940, to Oct 1, 1940.
that I last saw her alive on Oct 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

myocardial failure

Due to

Hypertensive heart disease

Due to

arteriosclerotic hypertension

Other conditions Hemiplegia
(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?

541

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

(M. D. or other)

Address

Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 2

District File Number 1040-161

Date Filed 10/24/40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.