

DEC 14 1940
Registration District No. 124

Primary Registration District No. 5173

Registrar's No. 5

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

1. PLACE OF DEATH: CAMDEN
 (a) County CAMDEN
 (b) City or town RURAL MURRAY TWP.
 (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

3. (a) PRINT FULL NAME SARAH E CLAIBORNE
 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 WIDOW
 6. (b) Name of husband or wife W.F. CLAIBORNE 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec 1 1858
 (Month) (Day) (Year)

8. AGE: Years 81 Months 17 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Sharp ✓
 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 14. Maiden name JANE ELLIS ✓
 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
 (b) Address _____

17. (a) BURIAL (b) Date thereof OCT 18 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CLAIBORNE CEM.

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County CAMDEN
 (c) City or town RURAL
 (If outside city or town limits, write "RURAL")
 (d) Street No. DECAUTERVILLE
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 17
 year 1940 hour 7 minute 15 A. M.

21. I hereby certify that I attended the deceased from Aug 1 1940 to Oct 7 1940
 that I last saw her alive on Oct 7 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis @ home

Due to _____

Due to _____

Other conditions were AG
 (Include pregnancy within 3 months of death)

Major findings: Of operations none
 Of autopsy none

Duration 170
 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? no

While at work? _____ (Specify type of place) _____
 (e) Means of injury _____

23. Signature E.P. Claiborne (M. D. or other) _____
 Address Dea. Director Date signed 10-22-40

RECEIVED

District Health Officer No. 7,

District File Number 12-40-1742

Date Filed 12-10-40

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..... *R. L. Palmer*.....

Licensed Embalmer No. 1161.....

P. O. Address London 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38340

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 121

Primary Registration District No. 5173

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Camden
(b) City or town Warren 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 Mo (b) County Camden
(c) City or town Rural
(If outside city or town limits write "RURAL")
(d) Street No. Decaturville
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Sarah E Claiborne

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race w

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

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 81 Months 11 Days 16
If less than one day _____ hr. _____ min.

9. Birthplace _____

Camden Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

unknown (City, town, or county) Tenn (State or foreign country)

14. Maiden name _____

15. Birthplace _____

Wright Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant A H Claiborne

(b) Address Decaturville Mo

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) NOV 23, 1940

(Date received local registrar)

(b) Miss Vella Claiborne

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 7
year 1940 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 _____

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) (e) Means of injury _____

23. Signature E C Claiborne (M. D. or other) _____

Address Camden Mo

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

SUPPLEMENTAL

