

S. No. 2  
-11-10-39  
5-17-39  
p. 10-10-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **38769**

Registration District No. **327**

Primary Registration District No. **5453**

Registrar's No. **14**

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

1. PLACE OF DEATH:

(a) County Grundy  
(b) City or town Rural Liberty Mo  
(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 lifetime years, months or days

8. (a) PRINT FULL NAME Sarah Amanda Chowning

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Wh 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 Nov 17 1859 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 11 29 — hr. — min.

9. Birthplace Sullivan Co. Mo (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business none

12. Name John Foster

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

14. Maiden name Martina Jones

15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Andy Foster

(b) Address Galt Mo

17. (a) Burial (b) Date thereof Nov 18-40 (Month) (Day) (Year)

(c) Place: burial or cremation East Galt Mo cemetery

18. (a) Signature of funeral director Dr Payne & Son

(b) Address Galt Mo

19. (a) 11-17-40 (b) W. Weston (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Grundy  
(c) City or town Galt

(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.? USA years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16  
year 1940 hour 7- minute 15 P.M.

21. I hereby certify that I attended the deceased from 11-14-40  
to 11-16, 1940,  
that I last saw her alive on 11-14-, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Shock from broken rt femur

Due to Fall

Due to fall

Other conditions myocarditis chronic  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 11-9-40

(c) Where did injury occur near Galt Grundy Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? in home

While at work? no (Specify type of place) (e) Means of injury Fell after

23. Signature W. Weston (M. D. or other)

Address Galt, Mo. Date signed 11-17-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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, above space should be left blank.**