

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39383

Registration District No. 625-

Primary Registration District No. 3031

Registrar's No. 149

1. PLACE OF DEATH:

(a) County Nodaway
(b) City or town Marvville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 weeks
(Specify whether years, months or days) 1

3. (a) PRINT FULL NAME Mrs. Sadie F. Anderson.
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 Otto Anderson 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased March 8, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 8 II hr. min.

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

10. Usual occupation Farm Home

11. Industry or business _____

FATHER { 12. Name Robert Pistole
13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name Sarah Williams
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address Marvville, Mo.

17. (a) Whiteville (b) Date thereof Nov. 20 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Whiteville Mo.

18. (a) Signature of funeral director _____

(b) Address Marvville Mo.

19. (a) Nov 20 1940 (b) Mamie E. Clardy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway
(c) City or town Marvville, Rural
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 19 day
year 1940 hour 8:30 minute A.M.

21. I hereby certify that I attended the deceased from July 1, 1940 to Nov 19, 1940
that I last saw her alive on Nov 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Is circumscribed by
Organ and Intestines
Due to _____

Due to _____
Other conditions ✓
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy none

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?
5-5-40
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature M. J. Clardy (Date signed) Nov 20 1940
Address Marvville Mo.

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.

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47

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. 1625

P. O. Address Mayville 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, above space should be left blank.

No. 2B
2-21-40
1-15-59

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 393 83

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 625

Primary Registration District No. 3031

Registrar's No.

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

MOORE

1. PLACE OF DEATH:

(a) County Madawney

(b) City or town Marionville
(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 _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County Madawney

(c) City or town Marionville
(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 Mrs Sadie E. Anderson

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 19
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.

4. Sex F

5. Color or race W

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

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

Immediate cause of death Carcinoma of right ovary and uterine tubes (Ovary pain)

Due to _____

Due to _____

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 65 Months 8 Days 11 If less than one day _____ min.

Other conditions _____ (Include pregnancy within 3 months of death) 49

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 _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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? _____

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

23. Signature T. C. Anderson (M.D. or other) _____

Address Marionville Mo Date signed _____

1-30-40

S-39383 - 1440