

DEC 16 1940

Registration District No. 668

Primary Registration District No. 3032

354

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1007 W 3.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 30 years _____
years, months or days) 2

3. (a) PRINT FULL NAME ANNA MARIE O'BRYAN

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 W. Dick O'Bryan 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 15 1877
(Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Joseph Huber

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

14. Maiden name Francis Knapp

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

16. (a) Informant Mrs. Flora Lewis

(b) Address Sedalia Mo.

17. (a) Burial (b) Date thereof Nov 11-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Balvany

18. (a) Signature of funeral director McLaughlin Bros
(b) Address Sedalia Mo.

19. (a) 11-11-40 (b) Mrs. Harry Sneed
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis
(c) City or town Sedalia
(If outside city or town limits, write "RURAL")
(d) Street No. 1007 W 3
(If rural, give location) 0
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9th
year 1940 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from Apr. 22, 1940 to 11/9, 1940
that I last saw her alive on Nov. 9, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Broncho-pneumonia Duration 10 days

Due to _____

Due to _____

Other conditions: Miss. Slegis 10 mos
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____

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? _____

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

23. Signature Frank H. Long M. D. or other _____
Address Sedalia Mo. Date signed 11/17/40

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

107A

RECEIVED
District Health Officer No. 8,
District File Number 12-16-40
Date Filed

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.....

Robert H. Reed

Licensed Embalmer No.

3746

P. O. Address.....

Idalia 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39463
Registrar's No. 354

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 668

Primary Registration District No. 3082

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

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(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 _____ (b) County _____
(c) City or town _____
(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 Anna Marie O'Bryan

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 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 63 Months 8 Days 24 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) _____ (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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 9
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 _____ and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia Duration _____

Due to _____ 82 W

Due to _____

Other conditions Hemiplegia
(Include pregnancy within 3 months of death)

Major findings: Fracture of Cervical Vertebrae
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)
Means of injury _____

23. Signature J. Francis B. Long M. D. or other MD
Address _____ Date signed 11/9/40

SUPPLEMENTAL

11

S-39463

1940