

No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42079**

Registration District No. **135**

Primary Registration District No. **3010**

Registrar's No. **117**

1. PLACE OF DEATH:

(a) County Cassell
(b) City or town Cassell
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
307 East 4th St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20
(Specify whether years, months or days) 88 yrs - 1 mo - 26 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cassell
(c) City or town Cassell
(If outside city or town limits, write "RURAL")
(d) Street No. 307 East 4th St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Sarah James Nowland

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color of race W 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Thomas B Nowland 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10 30 1852
(Month) (Day) (Year)

8. AGE: Years 88 Months 1 Days 26 If less than one day hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____

12. Name John James

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

14. Maiden name Elizabeth Ferguson

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

16. (a) Informant W D Nowland

(b) Address Cassell Mo

17. (a) Burial (b) Date thereof 11-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pat Hill Cem

18. (a) Signature of funeral director Walter Housh

(b) Address Cassell Mo

19. (a) 12/27-40 (b) Walter Housh
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 26
year 1940 hour _____ minute 9:30 P. M.

21. I hereby certify that I attended the deceased from Nov 5
1940 to Dec 26, 1940
that I last saw her alive on Dec 26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardia
Nephrositis (chronic)

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

Major findings:
Of operations _____
Of autopsy _____

Duration
2 1/2 hrs
2 yrs
PHYSICIAN
Underlines 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? _____

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

23. Signature Charles S Austin (M. D. or other)

Address Cassell Mo Date signed 12/27/40

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-8-41

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 my self

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

Signed R.M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton 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.