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FEB 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

2192

State File No. _____

Registration District No. 163

Primary Registration District No. 5232

Registrar's No. 7

1. PLACE OF DEATH: CEJAR
 (a) County _____
 (b) City or town RURAL Cedar 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

3. (a) PRINT FULL NAME SARAH ELLEN ROE
 3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife James C. Roe 6. (c) Age of husband or wife if alive DECD years
 7. Birth date of deceased June-9-1845
(Month) (Day) (Year)

8. AGE: Years 95 Months 7 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
 12. Name Samuel Shryer
 13. Birthplace Ky
(City, town, or county) (State or foreign country)
 14. Maiden name James Hance
 15. Birthplace Va
(City, town, or county) (State or foreign country)

16. (a) Informant James S Roe
 (b) Address 1 Callinger Mill, Mo R1

17. (a) Burial (b) Date thereof 1-16-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Preston Cemetery

18. (a) Signature of funeral director Worm-Siders
 (b) Address Eldorado Springs Mo

19. (a) 1-15-41 (b) JW Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Cedar
 (c) City or town RURAL CEDAR TWP
(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 Jan day 15
 year 1941 hour 1 minute 0 P. 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 Bedfast for 8 years

Due to No medical attendant

Due to for years death from natural causes, postnatal

Other conditions arterio sclerosis
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations 97
 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? 154

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

23. Signature Worm-Siders (M. D. or other) 3
 Address Eldorado Sp. Mo Date signed 1-15-41

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

RECEIVED

District Health Officer No. 7,

District File Number 2-41-261

Date Filed 2-7-41

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.....
....., 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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.