

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD.

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.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

FILED JUN 5 1941

17993

1. PLACE OF DEATH
 County Donnell Registration District No. 283
 Township Goldberry Primary Registration District No. 5324
 City..... (No.....) St..... Ward.....

2. FULL NAME Sarah Margaret Sappell
 (a) Residence, No..... Ward.....
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marion Sappell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-18-1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>79</u>	<u>8</u>	<u>9</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ✓

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ✓

10. Date deceased last worked at this occupation (month and year) **11. Total time (years) spent in this occupation**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Mo.

13. NAME Don't know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ✓

15. MAIDEN NAME ✓

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ✓

17. INFORMANT M. S. Sappell
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Walter Chapel DATE 5-16-1941

19. UNDERTAKER J. J. Mean
(ADDRESS) 1111 W. Main St. Marion Mo.

20. FILED 5 1941 G. W. Humphreys
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-14-1941

22. I HEREBY CERTIFY, That I attended deceased from Jan 1-1941 to May 14 1941.
 I last saw her alive on May 8 1941. Death is said to have occurred on the date stated above, at 10 A. m.
 The principal cause of death and related causes of importance were as follows:
valvular heart trouble
 Date of onset 1/10/41

Other contributory causes of importance: ✓

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify.....
 (Signed) T. Esterred, M. D.
 (Address) Marion Mo.

Has Not Embalmed.

J. J. Arman
Mortuary Co.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17993

Registration District No. 383

Primary Registration District No. 5934

Registrar's No.

1. PLACE OF DEATH:

(a) County Howell

(b) City or town Boedsberry T.P.
(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 Mo (b) County Howell

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Margaret Saffell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month 5 day 14
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F

5. Color or race W

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

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

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

8. AGE: Years 79 Months 8 Days 9 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-5-41 (b) J. W. Thompson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

Due to _____

Due to _____

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

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 J. E. Ferrell (M. D. or other)

Address Mountain View Date dictated _____

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

SUPPLEMENTARY

S-17993