

AUG 9 1941 532
Registration District No. _____

Primary Registration District No. 4318

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Lallato
(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 77 1 years, months or days

3. (a) PRINT FULL NAME Sarah Martha Jones

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 Widowed

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

7. Birth date of deceased July 29 - 1863
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Keeper

11. Industry or business _____

12. Name John Silbente

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

14. Maiden name Nancy Tate

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

16. (a) Informant's own signature Bertha Sinnock

(b) Address Lallato Mo

17. (a) Burial (b) Date thereof July 15 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lallato

18. (a) Signature of funeral director L. S. Christie

(b) Address Lallato Mo

19. (a) July 14 (b) Louise J. Smith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
(c) City or town Lallato
(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 July day 13
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 4 1941 to July 13 1941
that I last saw W alive on _____ and that death occurred on the date and hour stated above

Immediate cause of death Coronary Occlusion Duration _____

Due to Hypertension

Due to Cardiac Hypertrophy

Other conditions: 914A
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: _____

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 H. O. Nelson (M. D. or other) _____
Address Lallato Mo Date signed July 14

PHYSICIAN
Underline the cause to which death should be charged statistically.

WAXED - FANNED - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD
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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.

RECEIVED

District Health Officer No. 10

District File Number 8-41-147

Date Filed AUG 6 1941

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.