No. 2
11-10-39
5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILLED AUG 25 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26367

Registration District No. 834 Primary Registration District No. 6097 Registrar's No. 30

1. PLACE OF DEATH
(a) County Stoddard Dike Twp
(b) City or town Advance Mo Rt
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stoddard
(c) City or town Advance Mo Rt
(If outside city or town limits write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Sarah Abernathey
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race W.
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct-19-1865 (Month) (Day) (Year)
8. AGE: Years 75 Months 8 Days 11 If less than one day hr. min.
9. Birthplace Ballinger Co. (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Lambrick
13. Birthplace Ire (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Clarence Abernathey
(b) Address Advance Mo Rt
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1, 41 (Month) (Day) (Year)
(c) Place: burial or cremation Fairpenhole Cem
18. (a) Signature of funeral director Watkins Funeral Dir
(b) Address Dexter Mo
19. (a) 7-10-41 (Date received local registrar) (b) D. S. McGee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30 year 1941 hour 8 minute 3 a.m.
21. I hereby certify that I attended the deceased from Hypertension, 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 Cerebral Hemorrhage — Duration
Due to Hypertension about 2 yrs. ago.
Due to
Other conditions (Include pregnancy within 3 months of death) 13 H
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature John W. Wilson (M. D. or other)
Address Bloomfield Mo Date signed 6-30-41

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Office No. 8
District File Number 8H-1117
Date Filed 8-15-41

O. S. Mattu

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 w the above constitutes grounds for revocation of license.)

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