DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 6 1942

Registration District No. 359

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. ~~4212~~ 5504

State File No. 41985

Registrar's No. 11

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

1. PLACE OF DEATH:
(a) County Hickory
(b) City or town (Rural) Weaubleau 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 60 years
years, months or days)

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

3. (a) PRINT FULL NAME Sarah M. DURNELL

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

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John W. Durnell
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 28 (Day) 1854 (Year)

8. AGE:

Years	Months	Days	If less than one day
87	5	18	hr. min.

9. Birthplace Wheeling (City, town, or county) W. Virginia (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John Daniels
13. Birthplace Unknown (City, town, or county) England (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs Jim Bullington
(b) Address Flemington, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17 1941 (Month) (Day) (Year)
(c) Place: burial or cremation Durnell Chapel Cemetery
18. (a) Signature of funeral director E H Rimm
(b) Address Humansville Mo
19. (a) Dec 29 (Date received local registrar) (b) Tina V Owens (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 16 day 1941
year 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.

	Duration
Immediate cause of death Respiratory Failure	1545
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy None	

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 Wm G. R. Easton (M. D. or other) W.O.
Address Weaubleau, Mo Date signed Dec 16 1941

5 20 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 12-41-2076
Date Filed 1-5-42

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

Signed Walter J. Kiernan

Licensed Embalmer No. 3822

P. O. Address Lewiston Me.

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, fact should be so stated above.

V. S. No. 2B
10M—8-21-41
X29288

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State File No. 41985

Registration District No. 359 Primary Registration District No. 5504 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Hickory

(b) City or town Rural (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 60 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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 M. Durnell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M.

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 June 28 1854 (Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16 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 Respiratory failure

Due to

Due to Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

162 f

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Dr Gail R Easton (M. D. or other) D.O.

Address Wearbleau Mo Date signed March 16 42

SUPPLEMENTARY