

3-40  
-39  
X23159

State File No. \_\_\_\_\_

Registration District No. 799

Primary Registration District No. 4479

Registrar's No. 41

1. PLACE OF DEATH: Saline  
 (a) County: Saline  
 (b) City or town: State town  
 (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: \_\_\_\_\_  
 In this community: 20 years  
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: Mo (b) County: Saline  
 (c) City or town: State Mo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 224 West Lincoln  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME: Sarah Isabelle Daniel

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec day 17  
 year 1941 hour 11 minute 20 M.

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

21. I hereby certify that I attended the deceased from Sept - 1941 to Dec - 17 - 1941  
 that I last saw him alive on Dec - 17 - 1941  
 and that death occurred on the date and hour stated above.

4. Sex: Female 5. Color or race: white  
 6. (a) Single, widowed, widowed

Immediate cause of death: Cerebral apoplexy

6. (b) Name of husband or wife: \_\_\_\_\_  
 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years

Due to: Quarrel between persons

7. Birth date of deceased: February 1 - 1861  
 (Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days 16  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to: \_\_\_\_\_

9. Birthplace: Shenandoah Co Virginia  
 (City, town, or county) (State or foreign country)

Other conditions: \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

10. Usual occupation: house wife

Major findings: \_\_\_\_\_  
 Of operations: \_\_\_\_\_  
 Of autopsy: \_\_\_\_\_

11. Industry or business: \_\_\_\_\_

12. Name: Cross Crumville

13. Birthplace: Scott Cross  
 (City, town, or county) (State or foreign country)

14. Maiden name: Scott Cross

15. Birthplace: Scott Cross  
 (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Charles Deags

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) Burial (b) Date thereof: Dec 19-41  
 (Month) (Day) (Year)

(b) Date of occurrence: \_\_\_\_\_

18. (a) Signature of funeral director: Concord Funeral Home  
 (b) Address: State Mo

(c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

19. (a) Dec 19 41 (b) Daniel Danoulin  
 (Date received local registrar) (Registrar's signature)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 (Specify type of place) \_\_\_\_\_  
 (e) Means of injury: \_\_\_\_\_

23. Signature: M. C. Duggins (M. D. or other)  
 Address: State Mo Date signed: 12-18-41

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-14-42

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

working under my personal supervision.

Registered Apprentice No.

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, fact should be so stated above.