

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County RALLS
(b) City or town CENTER
(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)

3. (a) PRINT
FULL NAME

SARAH EMILY VAN NOY

3. (b) If veteran,
name war.

3. (c) Social Security
No.

4. Sex FEMALE

5. Color or
race White

6. (a) ~~Single~~ widowed, married
2

6. (b) Name of husband or wife

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

7. Birth date of deceased

NOVEMBER 4, 1870
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

71

1

11

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

12. Name

John H. Hollaway

13. Birthplace

St. Louis, Mo.

(State or foreign country)

14. Maiden name

Mrs. Stahl

15. Birthplace

St. Louis, Mo.

(State or foreign country)

16. (a) Informant

Wm. Van Noy

(b) Address

Center, Missouri

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Dec. 16, 1941
(Month) (Day) (Year)

(c) Place: burial or cremation

St. Peter's

18. (a) Signature of funeral director

Stephen C. Couch

(b) Address

Center of St. Louis

19. (a)

12/16/41
(Date received local registrar)

(b)

[Signature]
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County RALLS
(c) City or town CENTER
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month

Dec. 15 day

year 1941

hour 6

minute

A. M.

21. I hereby certify that I attended the deceased from Nov. 2

1941 to Dec. 15 1941

that I last saw her alive on Dec. 13 1941

and that death occurred on the date and hour stated above.

Immediate cause of death

Myocarditis

Duration

6 weeks

Due to

acute

Due to

unknown

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 sta-
tistically.

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

P. H. Brooke

(M. D. or other) Dr.

Address

Center, Mo.

Date signed 12/15/41

RECEIVED

District Health Officer No. 10

District File Number 1-42-89

Date Filed JAN 15 1942

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.

Signed.....

Registered Apprentice No.....

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.