

FILED APR 15 1942 793

Primary Registration District No. **6-038-44716**

Registrar's No. **57**

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

1. PLACE OF DEATH:

(a) County **SALINE**
(b) City or town **MALTA BEND**
(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 **30 YRS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~Missouri~~ **MO** (b) County **Saline 97**
(c) City or town **Malta Bend**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **SARAH LOUISE FLORENCE**

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

4. Sex **F 3** 5. Color or race **COL** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **THORNTON FLORENCE** 6. (c) Age of husband or wife if alive _____ years (Day) (Year) **46 1863**

8. AGE: Years **69** Months **4** Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **RANDOLPH, CO. MO U**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business

MOTHER FATHER { 12. Name **MILES HARVEY**
13. Birthplace **RANDOLPH, CO MO U**
(City, town, or county) (State or foreign country)
14. Maiden name **ELLEN WILLIAMS**
15. Birthplace **RANDOLPH, CO. MO U**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lutana Miller**
(b) Address **St. Joseph, Mo**

17. (a) **Burial** (b) Date thereof **2, 24, 42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MALTA BEND MO**

18. (a) Signature of funeral director **F. D. Ferguson**
(b) Address **Marshall Mo**

19. (a) **Mar 24 1942** (b) **Mo T. O. Westbrook**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **18**
year **1942** hour **10:00** minute **A.M.**

21. I hereby certify that I attended the deceased from **Dec 11**, 19**41** to **MARCH 18**, 19**42**;
that I last saw her alive on **MARCH 2**, 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Due to **ARTERIOSCLEROSIS**

Due to _____
Other conditions (Include pregnancy within 3 months of death) **83a**

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 **Robert R. Stanley** (or other) **D.O.**
Address **Malta Bend, Mo.** Date signed **3-23-42**

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 4-14-42

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.....

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

Signed.....

F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Marshall m

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.