

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24181**
Registrar's No. _____

FILED AUG 17 1942
Registration District No. **90**

Primary Registration District No. **5329**

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

1. PLACE OF DEATH:

(a) County **CRAWFORD**
(b) City or town **RURAL OAK HILL TOWNSHIP**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OAK HILL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **46 YRS.**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **CRAWFORD**
(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")
(d) Street No. **OAK HILL**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MARY EMILINE SOUDERS**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWER**

6. (b) Name of husband or wife **SAMUEL SOUDERS** 6. (c) Age of husband or wife if alive **DEAD** years

7. Birth date of deceased **JULY 6 1862**
(Month) (Day) (Year)

8. AGE: Years **80** Months **0** Days **8** If less than one day hr. _____ min. _____

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

10. Usual occupation **HOUSEWIFE**

11. Industry or business _____

MOTHER FATHER { 12. Name **WILLIAM Mr DANIEL**
13. Birthplace **NOT KNOWN** 9
(City, town, or county) (State or foreign country)
14. Maiden name **MARTHA BROWN**
15. Birthplace **TEA MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **JOSHUA SOUDERS**
(b) Address **OAK HILL MO**

17. (a) **BURIAL** (b) Date thereof **JULY 16 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **GIBSON CEM. OAK HILL MO**

18. (a) Signature of funeral director **W. F. Hattenstrater**
(b) Address **Quinsville Mo**

19. (a) _____ (b) **1308** (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **14**
Year **1942** hour **8** minute **A.** M.

21. I hereby certify that I attended the deceased from **8-12-42** 1942 to **6-16** 1943
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Valvular heart disease**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **928**

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **Edw Melliss** (M. D. number) _____
Address **Quinsville Mo** Date signed **7-10-42**

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 Malford H. H. Winter
Licensed Embalmer No. 383 F
P. O. Address Quersville Mo

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.

STANDARD CERTIFICATE OF DEATH

State File No. 24181

Registration District No. 90

Primary Registration District No. 5329

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Crawford
(b) City or 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 _____ (Specify whether years, months or days) 46 yrs.

3. (a) PRINT FULL NAME Mary Emilene Sanders

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

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased: July (Month) 6 (Day) 1942 (Year)

8. AGE: Years 90 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____ (City, town, or county) _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) July 8, 1992 (Date received local registrar) (b) Lillis Rodgers (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

[Faint, illegible text covering the majority of the page, appearing to be a list or series of entries.]

Handwritten signature or name at the bottom right of the page.