

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 21 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26677

Registration District No. 33

Primary Registration District No. 4044

Registrar's No. 8

1. PLACE OF DEATH:

(a) County BOONE
(b) City or town STURGEON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME MALINDA SIMS

3. (b) If veteran, name war ✓

3. (c) Social Security No. 2

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

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

7. Birth date of deceased JAN. 17 1861
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 1 If less than one day hr. min.

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

10. Usual occupation HWF

11. Industry or business _____

12. Name THOMAS BARNES

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

14. Maiden name SARAH ROBERTS

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

16. (a) Informant's own signature W. H. Jones

(b) Address St. Louis, Mo.

17. (a) BURIAL (b) Date thereof July 20 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. CARMEL

18. (a) Signature of funeral director Barnes & Barnes

(b) Address Sturgeon, Mo.

19. (a) July 19 1942 (b) Mary Montgomery
(Date recorded local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BOONE
(c) City or town STURGEON
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18 year 1942 hour 10 minute 00 P.M.

21. I hereby certify that I attended the deceased from June 4, 1941, to July 18, 1942
that I last saw her alive on July 18, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cerebral embolism

Due to fracture of right hip

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 2

23. Signature Dr. Joseph H. Jones (M. D. or other) Dr.

Address Sturgeon, Mo. Date signed 7/20/42

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.....

A. E. Booth

Licensed Embalmer No.....

4087

P. O. Address.....

Sturgeon, 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, above space should be left blank.