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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

30697

State File No.

FILED OCT 8 1942

Registration District No. 474

Primary Registration District No. 5644

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 2 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 54

(c) City or town Lexington Mo Rural 0
(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 0

3. (a) PRINT FULL NAME Sarah Quinn

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Fe

5. Color or race W

6. (a) Single, widowed, married, divorced 2 widow

6. (b) Name of husband or wife —

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

7. Birth date of deceased Dec (Month) 25 (Day) 1862 (Year)

8. AGE: Years 79 Months 9 Days 0 If less than one day hr. min.

9. Birthplace South Bend (City, town, or county) Ind 1 (State or foreign country)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " " " 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Not Known
15. Birthplace " " " 9 (City, town, or county) (State or foreign country)

16. (a) Informant Wm Henderson
(b) Address Lexington, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 27-42 (Month) (Day) (Year)
(c) Place: burial or cremation Plattsmouth, Neb.

18. (a) Signature of funeral director Winkler
(b) Address Lexington, Mo

19. (a) 9-26-42 (Date received local registrar) (b) Mrs. Fred Schwab (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25 year 1942 hour 6:15 minute a. M.

21. I hereby certify that I attended the deceased from Sept 22 - 1 1942 to Sept 24 1942 that I last saw her alive on Sept 23 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Myocardial degeneration	12 hr
Due to Hypostatic Pneumonia	48 hr
Due to Senility	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dr J. E. Seltzam (M.D. or other) D.O.
Address Lexington Mo Date signed 9/25/42

1158

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-7-42

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 Geo. A. McKean

Licensed Embalmer No. 2983

P. O. Address Livingston Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30697

Registration District No. 174 Primary Registration District No. 5644 Registrar's No. 57

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

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lexington
(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)

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

3. (a) PRINT FULL NAME Sarah Quinn

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 25 (Day) 1862 (Year)

8. AGE: Years 79 Months 9 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death acute myocardial degeneration — Duration 12 h

Due to Hypostatic Bronchial Pneumonia — 48 hrs.

Due to Senility

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY