S. No. 2
M—5-42
5-17-39
X32873

1734

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 9 1943

STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 94 Primary Registration District No. 405-8 Ho 62 Registrar's No. 49

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

3 0 0

1. PLACE OF DEATH:
(a) County: Caldwell
(b) City or town: Cowgill
(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 ..... (Specify whether years, months or days)
In this community: 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Caldwell
(c) City or town: Cowgill 3
(If outside city or town limits, write "RURAL")
(d) Street No. 3
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Sarah E. Connor
3. (b) If veteran, name war: ✓
3. (c) Social Security No. ✓
4. Sex: Fe 1
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: David Connor
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: Dec (Month) 5 (Day) 1853 (Year)

8. AGE: Years 89 Months 1 Days 23 If less than one day ..... hr. ..... min.

9. Birthplace: — (City, town, or county) Ill. 1 (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: .....
FATHER
12. Name: Unknown 9
13. Birthplace: (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Unknown
15. Birthplace: (City, town, or county) 9 (State or foreign country)
16. (a) Informant: Mrs Fib Phillips
(b) Address: Braymer, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-31-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Skinner Cem
18. (a) Signature of funeral director: Bernard F. Mead
(b) Address: Braymer, Mo
19. (a) 1-28-43 (Date received local registrar) (b) E. A. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 28th year 1943 hour 1 minute 4 P.M.
21. I hereby certify that I attended the deceased from Jan. 9, 1943, to Jan 28th, 1943
that I last saw her alive on Jan. 28th, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia
Due to: Shock and old age, she had a bad fall
Due: Jan. 9th

Other conditions (Include pregnancy within 3 months of death): O.C. Kilbourn

Major findings:
Of operations: .....
Of autopsy: .....

Duration

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: O.C. Kilbourn (M. D. or other)
Address: Cowgill, Mo. Date signed: Jan. 28th

1151

(Licensed Embalmer's Statement on Reverse Side)

## 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 Bernard L. Mead

Licensed Embalmer No. 2801

P. O. Address Trenton, 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.**

S. No. 2B
M—8-21-41
I X29288

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

State File No. 1734

Registration District No. 44 Primary Registration District No. 4062 Registrar's No. 49

**1. PLACE OF DEATH:**
(a) County: Caldwell
(b) City or town: Cowgill (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)
In this community

**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 E. Connor
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) 5 (Day) 1853 (Year)
8. AGE: Years 89 Months Days If less than one day hr. 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
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 January 8 Day year 1943 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 Lobar Pneumonia Duration
Due to Shock & old age, she had a bad fall Jan 9
Due to
Other conditions (Include pregnancy within 3 months of death) Tb a
Major findings:
Of operations 18
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) accident
(b) Date of occurrence Jan. 9.
(c) Where did injury occur? Cowgill (City or town) Caldwell (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home of Daughter (Specify type of place)
While at work? no (e) Means of injury fall
23. Signature O. C. Kilbourn (M. D. or other)
Address Date signed

SUPPLEMENTARY