

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 13 1943

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 44

1. PLACE OF DEATH:

(a) County. Jasper
(b) City or town. Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
909 Orchard St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 88 Years (Specify whether)
years, months or days)

3. (a) PRINT FULL NAME SARAH JANE COMER

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, 2 divorced Widowed
6. (b) Name of husband or wife Wm. Comer 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 12, 1851
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
91 4 3 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Unknown Lasater 9
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. George Rush

(b) Address Carthage, Missouri

17. (a) Burial (b) Date thereof 2-18-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer

(b) Address 1208 Garrison, Carthage, Mo.

19. (a) Feb 17 '43 (b) Elizabeth Corplins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
(c) City or town Carthage 3
(If outside city or town limits, write "RURAL")
(d) Street No. 909 Orchard St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15,
year 1943 hour 11:00 minute P. M.

21. I hereby certify that I attended the deceased from 1939 19. to 2-15 19. 43
that I last saw her alive on 2-15 19. 43
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, hypostatic ✓
Duration _____

Due to Cerebral hemorrhage

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Russell Smith MD (M. D. or other) _____
Address Carthage Mo Date signed 2-17-43

43-2-162

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.....

Licensed Embalmer No.

P. O. Address

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 68-83

Registration District No. _____

Primary Registration District No. 3028

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(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

3. (a) PRINT FULL NAME Sarah J. Comer

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

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

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

7. Birth date of deceased Oct 12 (Month) (Day) (Year)

8. AGE: Years 91 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jasper
(c) City or town Carthage (If outside city or town limits, write "RURAL")
(d) Street No. 909 Orchard St (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13 year 1943 hour _____ minute _____ M.

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

pneumonia hypostatic
bronchial

Due to _____

Due to _____

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

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)
(b) 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

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[illegible]