S. No. 2
M—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED [illegible] 1943

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Hoche 6960

State File No.

Registration District No. 200 Primary Registration District No. 5728 Registrar's No. 10

**1. PLACE OF DEATH:**

(a) County Macon

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

(c) Name of hospital or institution: Rose A. Grant Ings
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community all her life
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Macon 61 0

(c) City or town Anabel 0
(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 0

**3. (a) PRINT FULL NAME** Sarah Caroline Richardson

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female

5. Color or race Ow

6. (a) Single, widowed, married, divorced ✓ 3

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased Nov (Month) 7 (Day) 1856 (Year)

**8. AGE:** Years 87 Months — Days 21 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation House wife

11. Industry or business ~~[illegible]~~

FATHER
12. Name Wm Graves
13. Birthplace (City, town, or county) Ky. 1 (State or foreign country)

MOTHER
14. Maiden name Prunella Reynolds
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Mazo Lanio
(b) Address 1092 E 26 - Kansas City - Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Graves Chapel

18. (a) Signature of funeral director E E Hopper
(b) Address Clarence Mo

19. (a) Feb. 4, 1943 (Date received local registrar) (b) Jora B. Hunckler (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month Nov day 29 year 1942 hour 6 minute pm M.

21. I hereby certify that I attended the deceased from Nov 9, 1937 to Nov 29, 1942 that I last saw her alive on Nov 29, 1942 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Chronic myocarditis | 6 years |
| Due to Thyrotoxicosis | 10 yrs |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

93 D

**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 D L Harlan (M. D. or other) MD 8

Address Clarence Mo Date signed Jan 1943

1037 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-43-289
Date Filed FEB 15 1943

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**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 E. E. [illegible]

Licensed Embalmer No. 4260

P. O. Address [illegible]

**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.**

Med