

No. 2
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17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14267

ED. MAY 8 1943
Registration District No. 20

Primary Registration District No. 4194

State File No. _____

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Gentry

(b) City or town Albany
(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 Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED: 38

(a) State Missouri (b) County Gentry

(c) City or town Albany 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 _____

3. (a) PRINT FULL NAME Sarah Jane Hankins

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

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

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

7. Birth date of deceased Sept. 14, 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

81 7 8 _____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER { 12. Name John F. Gillès pie

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

14. Maiden name Mary Thompson

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

16. (a) Informant Mrs. Robert Giles

(b) Address Albany, Mo.

17. (a) Burial (b) Date thereof 4-24-43
(Burial, cremation, or renoval) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Cemetery

18. (a) Signature of funeral director W. H. Burch
(b) Address Albany Mo.

19. (a) April 24-1943 (b) Homer W. DeBater
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1943 hour 12 minute 05 A. M.

21. I hereby certify that I attended the deceased from Feb 9 1943 to April 21 1943
that I last saw her alive on April 21 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Complications from Broken Right Femur Hip Joint

Other conditions Heart trouble
(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: 0.38V

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence Feb 9, 1943

(c) Where did injury occur? at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Broken Hip
(Specify type of place) (e) Means of injury _____

While at work? _____

23. Signature J. N. Barges (M. D. or other) _____
Address Albany Mo. Date signed 4-23-43

(Licensed Embalmer's Statement on Reverse Side)

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

X26390

0-8

111

1943

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Clifford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14267
Registrar's No. 43

Registration District No. 120

Primary Registration District No. 4194

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

1. PLACE OF DEATH:

(a) County Sevier
(b) City or town Albany
(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 _____ life years, months or days

3. (a) PRINT FULL NAME Larsh J Hankins

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

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

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

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

8. AGE: Years Months Days (If less than one day) min.

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

10. Usual occupation

11. Industry of 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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 21 year 1943 hour _____ minute _____ M.

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

Immediate cause of death: complications from broken right femur hip joint
Due to _____
Due to heart trouble

Other conditions (include pregnancy within 3 months of death) 186a

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) accident

(b) Date of occurrence Feb 10 1943

(c) Where did injury occur? Albany County MO (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, or public place? fall

While at work? yes (Specify type of place) (e) Means of injury fall

23. Signature J N Berger (M. D. or other)

Address _____ Date signed 2/24/43

S-14267