

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14742

D. MAY 11 1943
Registration District No. 179

Primary Registration District No. 5667

Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Bedford
(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) 1 yr

8. (a) PRINT FULL NAME SARAH JANE BARNES

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

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

6. (b) Name of husband or wife Laurel Barnes 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased March 14 1856
(Month) (Day) (Year)

8. AGE: Years 87 Months 0 Days 15 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Louis Presley

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

14. Maiden name Unknown

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

16. (a) Informant Laurel Presley

(b) Address Louis Mo.

17. (a) Burial (b) Date thereof Mar 30 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sulphur Lick Beam

18. (a) Signature of funeral director Wayne Mc Coy

(b) Address Tracy Mo.

19. (a) April 20 43 (b) Wm. H. Jackson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln
(c) City or town Rural
(If outside city or town limit, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 29
year 1943 hour 5 minute 00 P. M.

21. I hereby certify that I attended the deceased from Jan 11 1943 to Jan 11 1943
that I last saw her alive on Jan 11 1943
and that death occurred on the date and hour stated above.

Immediate cause of death. Chronic myocarditis

Due to Chronic Bronchitis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations. 93d
Of autopsy.

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 U

23. Signature J. H. Hoegs (M. D. or other) M.D.
Address W. H. Litchfield Mo. Date signed 3/30-43

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

MOTHER FATHER

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. *3586*

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, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

July April 43
State File No. _____

Registration District No. 179

Primary Registration District No. 5667

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Lincoln
(b) City or town Redford (Rural)
(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) (Specify whether
years, months or days)

3. (a) PRINT
FULL NAME Sarah Jane Sauer

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 m

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

7. Birth date of deceased March 14
(Month) (Day) (Year)

8. AGE: Years 87 Months 0 Days 13 If less than one day
min. _____

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

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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 _____ (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 _____ Day _____ Year _____ hour _____ minute _____ M.

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

- Due to _____

- Due to _____

- Other conditions _____
(include pregnancy within 3 months of death)

- Major findings: _____
Of operations _____

- Of autopsy _____

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 _____ (M. D. or other) _____

- Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

5-14742

5-14742