S. No. 2
-11-10-39
5-17-3
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED AUG 25 1943

State File No. 25765

FILED AUG 9 1943

Registration District No. 76

Primary Registration District No. 5947

Registrar's No.

81
0
0

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

1. PLACE OF DEATH:

(a) County Phelps Co

(b) City or town St James Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Soldiers Home (Specify whether
In this community 3 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps 81 0 0

(c) City or town St James Mo
(If outside city or town limits write "RURAL")

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

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

3. (a) PRINT FULL NAME Sarah A Hart

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race 1

6. (a) Single, widowed, married, divorced Wid 2

6. (b) Name of husband or wife James M. Hart

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

7. Birth date of deceased 2 (Month) - 18 (Day) 1880 (Year)

8. AGE: Years 63 Months 5 Days 13 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Dont Know
13. Birthplace " " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace " " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Soldiers Home Record
(b) Address St James Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8 (Month) - 2 (Day) - 43 (Year)
(c) Place: burial or cremation Marionville Mo

18. (a) Signature of funeral director W. Hickleder
(b) Address St James Mo

19. (a) 7-31-1943 (Date received local registrar) (b) Chauncie Dickson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7-31 day
year 43 hour minute M.

21. I hereby certify that I attended the deceased from January, 1942, to July 31, 1943
that I last saw h[illegible] alive on July 30, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardio-Renal Syndrome	3 mo
Due to Myocarditis	6 mo
Due to	
Other conditions (Include pregnancy within 3 months of death) 13/a	

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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature William H Brewer (M. D. ~~or other~~)
Address St James Mo Date signed 7/31/43

(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 W. E. Lichlinder

Licensed Embalmer No. 1970

P. O. Address St James Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 10 1943

State File No.

Registration District No. 276 Primary Registration District No. 5947 Registrar's No.

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town St James Twp
(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 A. Hart

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race White

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 Feb. (Month) 18 (Day) 1880 (Year)

8. AGE: Years 63 Months 5 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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 July 5 day
year 1943 hour A.M. minute M.

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

Immediate cause of death	Duration
Due to	
Due to	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-25765