

FILED JAN 13 1943

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

(a) County Monroe Registration District No. 226
 (b) Township Woodburn Primary Registration District No. 5802
 (c) City Holiday R.R. (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

Registered No. 57**2. PRINT FULL NAME**

(a) Residence, No. _____ St. (If nonresident, give city or town and State) 1
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph Sanders

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7/5/1857

7. AGE YEARS 86 MONTHS 9 DAYS 18 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe Co. Mo.

13. NAME Samuel Norton Pickett

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe Co. Mo.

15. MAIDEN NAME Mildred Taine

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe Co. Mo.

17. INFORMANT (ADDRESS) Mrs Tom Woods
Madison, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove DATE 11/25/43

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Walter Thompson
Madison, Mo.

20. FILED 11/24 1943 Otto Hedberg
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 23, 1943

22. I HEREBY CERTIFY, That I attended deceased from July 25, 1943 to November 21, 1943
 I last saw her alive on November 21, 1943 Death is said to have occurred on the date stated above, at 3 p. m.
 The principal cause of death and related causes of importance were as follows:

Myocardial degeneration

Other contributory causes of importance:
Hyper tension and nephrosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? Chemical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) M. D. Woland, M. D.
 (Address) Madison, Mo.

RECEIVED

District Health Officer No. 10

District File Number... *1-44-202*

Date Filed **JAN 12 1944**

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 *Mrs. F. W. Thompson*

Licensed Embalmer No. *3282*

P. O. Address *Madison, W.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town 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

3. (a) PRINT FULL NAME Georgia A. Sanders

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Feb. 5 (Month) (Day) (Year)

8. AGE: Years 86 Months _____ 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) _____ (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 _____ (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 Nov Day 23 Year 1943 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____

that I last saw him _____ alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Myocardial degeneration

hypertension +

Due to nephritis

chronic

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. A. Koland (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-43136