

FILED FEB 9 1944

Registration District No. 256

Primary Registration District No. 4221

Registrar's No. 2

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Denver, Colorado
(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 1
(Specify whether
In this community 65 years
years, months or days)

3. (a) PRINT FULL NAME Sarah Elizabeth Haney
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race w 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Henry Haney 6. (c) Age of husband or wife if alive 20 years (Month) (Day) (Year) 1861

8. AGE: Years 82 Months 11 Days 22 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____
MOTHER FATHER { 12. Name William George McClure
13. Birthplace Ill. (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Arthur Haney
(b) Address Houston, Mo.

17. (a) Burial (b) Date thereof 1/16/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hills

18. (a) Signature of funeral director Raymond D. Elliott
(b) Address Houston, Mo.

19. (a) 1/13/44 (b) Mrs. Ella Duff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 107
(a) State Mo. (b) County Texas 0
(c) City or town Houston, Mo. 0
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 12
year 1944 hour 12 minute 0 P.M.

21. I hereby certify that I attended the deceased from Dec 20, 1940, to Jan 12, 1944, that I last saw her alive on Jan 11, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death pulmonary tuberculosis 6 mo.
Duration

Due to _____
Due to _____
Other conditions Chronic myocardial degeneration 2 yrs.
(Include pregnancy within 3 months of death)

Major findings: Of operations 13 fl
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 _____
23. Signature Henry R. Rosy (M. D. or other) D.O.
Address Houston, Mo. Date signed 1-13-44

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

FEB 9 19

RECEIVED

District Health Officer No. 5

District File Number 24498

Date Filed 2-4-44

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 Frank E. Hood

Licensed Embalmer No. 4026

P. O. Address Houston, Tex

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.

Registration District No. 356

Primary Registration District No. 4521

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Houston
(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 65 yr.
years, months or days)

3. (a) PRINT FULL NAME Sarah E. Honey
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 W

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

7. Birth date of deceased Jan. 20 1944
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 12 If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 Jan Day 12 year 1944 hour _____ minute _____ M.

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

that I last saw him _____ alive on _____ 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 8 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? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

4709