

FILED APR 12 1944

Registration District No. 20.5

Primary Registration District No. 4316

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Mason  
 (b) City or town New Cambria  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 23 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mason  
 (c) City or town New Cambria  
 (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 LUNDAY

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 Divorced, Widowed

6. (b) Name of husband or wife Philip R. Lunday 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DECEMBER 2 1866  
 (Month) (Day) (Year)

8. AGE: Years 77 Months 3 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Press Green

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

14. Maiden name Margaret Wilton

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

16. (a) Informant Forest Call

(b) Address Callao, Mo

17. (a) Burial (b) Date thereof March 10, 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dodson Cemetery

18. (a) Signature of funeral director W. H. Killeland

(b) Address New Cambria, Mo.

19. (a) Mar 10, 1944 (b) Almena M. Killeland  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8  
 year 1944 hour 7 pm minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Jan 1st 1944 to Mar 9 1944  
 that I last saw her alive on Mar 9 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis Duration 6 mo

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions Acute Duration 1 mo  
 (Include pregnancy within 3 months of death)

Major findings: no  
 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 Op West (M. D. or \_\_\_\_\_)  
 Address New Cambria Mo Date signed Mar 10, 1944

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

**RECEIVED**

**District Health Officer No. 10**

District File Number 4-44-7521

Date Filed APR 1 1 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 H. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria, 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.**