

Registration District No. 254

Primary Registration District No. 5860

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon  
(b) City or town Koshkonong (Rural) Hub City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Shiloh  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon  
(c) City or town Koshkonong (Rural)  
(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 Sarilda Elizabeth Jewell

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 Married

6. (b) Name of husband or wife Doc Jewell 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased August 27 1854  
(Month) (Day) (Year)

8. AGE: Years 89 Months 5 Days - If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Greene County Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name A. N. Wiggs

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

14. Maiden name Elizabeth Braden

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

16. (a) Informant Albert Jewell

(b) Address Koshkonong, Mo. Route 2

17. (a) Burial (b) Date thereof 1/28/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shiloh Cem.

18. (a) Signature of funeral director Doc Jewell

(b) Address Hub City, Mo.

19. (a) 3-10-44 (b) Joe O. Williams  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27  
year 1944 hour 8 minute 00 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 Chronic Valvular Heart Disease  
& Myocardial Failure

Due to Seriously

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 Joe O. Williams (M. D. or other) MD  
Address Hub City, Mo. Date signed 3-7-44

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

75  
0  
0

25  
6

92d

1112

RECEIVED

District Health Officer No 5,  
District File Number 444234  
Date Filed 4-8-44

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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.....

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, fact should be so stated above.**