

FILED MAR 18 1944
375

Primary Registration District No. **6281**

Registrar's No. **48**

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

1. PLACE OF DEATH:
 (a) County **Wright**
 (b) City or town **Manes (rural VanBuren twp)**
 (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.....
 In this community **Life**
 years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Wright**
 (c) City or town **Manes (Rural)**
 (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 Isabelle Carder**
 (b) If veteran, name war.....
 (c) Social Security No.....

20. DATE OF DEATH: Month **Jan** day **26**
 year **1944** hour **2** minute **P.** M.

4. Sex **Female** **5. Color or race** **white**
6. (a) Single, widowed, married, divorced **Widow**
(b) Name of husband or wife **James Robert Carder**
6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **October** **25** **1876**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Jan. 15 19 **27** to **Jan. 26** 19 **44**
 that I last saw her alive on **Jan. 13** 19 **44**
 and that death occurred on the date and hour stated above.

8. AGE: Years **67** Months **3** Days **1**
 If less than one day
 hr. min.

Immediate cause of death
Chronic Nephritis
 Duration **1 yr**

9. Birthplace **Wright Co Missouri**
 (City, town, or county) (State or foreign country)
10. Usual occupation **Housekeeper**

Other conditions
 (Include pregnancy within 3 months of death)
Major findings:
 Of operations.....
 Of autopsy.....

11. Industry or business
12. Name **Marion Hanson**
13. Birthplace **Dont know** **Dont know**
 (City, town, or county) (State or foreign country)
14. Maiden name **-----Perkins**
15. Birthplace **Dont know**
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
131

16. (a) Informant **Edna Carder**
(b) Address **Rayborn MO**

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.....

17. (a) Burial (b) Date thereof **Jan 27, 1944**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Green Mountain**
18. (a) Signature of funeral director **None**
(b) Address **XXXXXXXXXXXXXXXXXX**
19. (a) 2-4-44 (b) **W. J. ...**
 (Date received local registrar) (Registrar's signature)

23. Signature **J. R. Matt** (M. D. or other)
Address **Partville Mo.** **Date signed** **1/27/44**

RECEIVED
District Health Officer No. 6;
District File Number 344-339
Date Filed MAR 16 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

George Stapf

Licensed Embalmer No.

Not Embalmed

P. O. Address

Wm. Stone 220

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.