

FILED MAY 11 1944

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1000

Registrar's No. 362

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Sisters Hospital  
(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 & days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
(c) City or town Savannah 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 Marjorie Vernelle Sample

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

4. Sex Female / Color or race White  
5. (a) Single, widowed, married, divorced, Single

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

7. Birth date of deceased July - 6 - 1916  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
-27 - 6 - 17 hr. min.

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

10. Usual occupation Housekeeping

11. Industry or business at home

12. Name Herby E. Sample

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

14. Maiden name Mattie Cottrell

15. Birthplace unknown Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant H. E. Sample

(b) Address Savannah Mo.

17. (a) B (b) Date thereof Apr 2 - 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stewartsville MO.

18. (a) Signature of funeral director J. G. Lyon

(b) Address Stewartsville Mo.

19. (a) 4-1-44 (b) Rose Herzog  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31  
year 1944, hour 4 minute 20 A. M.

21. I hereby certify that I attended the deceased from Mar 1944 to 31st Mar 1944

that I last saw h. & R. alive on 3/18/44 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia Duration \_\_\_\_\_

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

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

Other conditions Heart insufficiency  
(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, or farm, or industrial place, in public place? ✓

While at work ✓ (Specify type of place) (e) Means of injury ✓

23. Signature J. G. Thompson (M. D. or other) MD

Address 825 Charles Date signed Mar 31/44

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

MOTHER FATHER

1233

**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

*F. G. Lyon*

Licensed Embalmer No. 952.

P. O. Address. Stewartsville 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.**