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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15314

FILED MAY 15 1944

Registration District No. 243

Primary Registration District No. 4365

Registrar's No. 12

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

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Newtonia
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton
(c) City or town Newtonia
(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 Sarah Jane Kirk

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 Widow
6. (b) Name of husband or wife M. T. Kirk 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 13 1860
(Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business _____
12. Name Jess Beavers
13. Birthplace N. Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Testerman
15. Birthplace N. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. B. Bales

(b) Address Neosho Missouri

17. (a) Burial, cremation, or removal Burial (b) Date thereof 4-12-44
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Cemetery

18. (a) Signature of funeral director W. B. Bales

(b) Address Neosho Missouri

19. (a) April 16 - 44 (b) Sarah Jane Kirk
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1944 hour 8 minute 40 A. M.

21. I hereby certify that I attended the deceased from April 9th 1944 to April 10th 1944
that I last saw her alive on April 10th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 2 days

Due to Arteriosclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) gla

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? _____

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

23. Signature Charles S. Sutton (M.D. or other) _____
Address 113 Hasky Neosho Mo. Date signed 4/12/44

1511

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

5-11-44

District Health Officer No.

District File Number 544-99.....

Date Filed 5-11-44.....

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 J. B. Bigham.....

Licensed Embalmer No. 2689.....

P. O. Address Keosauqua 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.