V. S. No. 2
00M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 13 1944

Registration District No. 383

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5613

State File No. 21917

Registrar's No. 99

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Rural - Hoberg Twnshp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mt. Vernon Route 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 2 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper 49
(c) City or town Carthage 1
(If outside city or town limits, write "RURAL") 3
(d) Street No. 610 Cedar St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Sarah Jane Devers
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Huston Devers
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased November (Month) 20 (Day) 1867 (Year)
8. AGE: Years 76 Months 7 Days 3 If less than one day ____ hr. ____ min.
9. Birthplace Cameron (City, town, or county) Missouri (State or foreign country)
10. Usual occupation housewife
11. Industry or business ----
12. FATHER Name Frank Sell
13. FATHER Birthplace unknown (City, town, or county) Penn (State or foreign country)
14. MOTHER Maiden name Kate Dietrich
15. MOTHER Birthplace unknown (City, town, or county) Penn (State or foreign country)
16. (a) Informant Mrs. Loren V. Rose
(b) Address Rt. 3, Mt. Vernon, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Van Buren Cemetery
18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Missouri
19. (a) 6/26/44 (Date received local registrar) (b) Andy Crawford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23 year 1944 hour 2:20 minute a M.
21. I hereby certify that I attended the deceased from 4/10 1944, to 6/23 1944, that I last saw him alive on 6/23 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Cachexia
Due to Ca of Stomach
Due to ____
Other conditions (Include pregnancy within 3 months of death) H6
Major findings: Of operations ____
Of autopsy ____

Duration

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature Kenneth Flower (M. D. or other)
Address Mt. Vernon, Mo. Date signed 6/24/44

1338 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 744-771
Date Filed JUL 11 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 Emma R. Kneel

Licensed Embalmer No. 291

P. O. Address Carthage

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.