

FILED AUG 8 1944  
Registration District No. **35**

Primary Registration District No. **3011**

Registrar's No. **62**

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Carrollton, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Atwood Hospital  
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Sarah Waddill

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 Child

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

7. Birth date of deceased July 21 1944  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 6 hr. \_\_\_\_\_ min.

9. Birthplace Carrollton Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Child

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

MOTHER FATHER

12. Name Orison Waddill

13. Birthplace Schroeder, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Parkins

15. Birthplace Carroll Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Orison Waddill

(b) Address Carrollton, Mo.

17. (a) Burial (b) Date thereof July 22, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olive

18. (a) Signature of funeral director Stanley General

(b) Address Carrollton, Mo.

19. (a) 7-22-44 (b) Mrs. James Kaffety  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

(c) City or town Carrollton  
(If outside city or town limits, write "RURAL")

(d) Street No. 509 W. Benton  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7-21 day \_\_\_\_\_ year 44 hour \_\_\_\_\_ minute 8 1/2 M.

21. I hereby certify that I attended the deceased from 7-21-44 to 7-21-44

that I last saw her alive on 7-21-44, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (6 1/2 months)

Due to Miscarriage

Due to Shock

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

159

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) \_\_\_\_\_

(a) Means of injury \_\_\_\_\_

23. Signature Seymour S. M.D. (M. D. or other) \_\_\_\_\_

Address Carrollton Date signed 7-22-44

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

RECEIVED

District Health Officer No. 8,

File Number

8-7-44

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.....

working under my personal supervision.

Registered Apprentice No.....

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.**