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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 15 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25481

State File No.

Registration District No. 282 Primary Registration District No. 5971 Registrar's No. 16

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

1. PLACE OF DEATH:
(a) County Polk
(b) City or town Bolivar
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Maryon
(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 Mo. (b) County Polk 84
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. just N of city limits
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Sarah Jane Austin
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 Married
6. (b) Name of husband or wife Tom
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased March 1 (Month) 1 (Day) 1897 (Year)

8. AGE:	Years	Months	Days	If less than one day
	47	3	12	hr. min.

9. Birthplace Bolivar Mo. 0
(City, town, or county) (State or foreign country)
10. Usual occupation H-W.
11. Industry or business
FATHER
12. Name Jim Kelsey
13. Birthplace Buffalo Mo. 0
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Daisy Odor
15. Birthplace Bolivar Mo. 0
(City, town, or county) (State or foreign country)
16. (a) Informant Tom Austin
(b) Address Bolivar Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16-44 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood
18. (a) Signature of funeral director Hutcheson & Co.
(b) Address Bolivar Mo.
19. (a) June 20, 1944 (Date received local registrar) (b) Alice Palen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 year 1944 hour 8 minute 30 P.M.
21. I hereby certify that I attended the deceased from June 1943 to June 1944 that I last saw her alive on June 13 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute heart failure	1 day
Due to: Chronic myocarditis	10 yrs
Due to: Rheumatic fever in childhood	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy
930

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 Joyce C McCrane (M.D. or other)
Address Bolivar Date signed 6-19-44

1297

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 7-44-957
Date Filed 8-14-44

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 Earl Pitts

Licensed Embalmer No. 3246

P. O. Address Bolivar 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.