

FILED AUG 11 1944

State File No. _____

Registration District No. 341

Primary Registration District No. 3075

Registrar's No. 36

1. PLACE OF DEATH:
(a) County Stoddard Co.
(b) City or town Dexter, Mo.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community _____
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Stoddard
(c) City or town Dexter, Mo.
(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 E WAGGNER

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 11
year 1944 hour 8 minute 15 M.

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 Widowed
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 17 1860
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 2nd, 1944 to July 11th, 1944
that I last saw her alive on July 9, 1944
and that death occurred on the date and hour stated above.
Immediate cause of death Arteriosclerosis Duration _____

8. AGE: Years Months Days If less than one day
84 4 24 _____ hr. _____ min.

Due to Arteriosclerosis
Nephritis + Arterio-sclerosis
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Free Town Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Lisam Cordery
13. Birthplace Maryland
(City, town, or county) (State or foreign country)
14. Maiden name Mary Nell
15. Birthplace Ind.
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy no
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Ira Malone
(b) Address Dexter, Mo.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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?

17. (a) Burial (b) Date thereof 7-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Synagogue Home Ind.

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

18. (a) Signature of funeral director Watkins Funeral Service
(b) Address Dexter, Mo.
19. (a) 7-20-44 (b) H. O. Smith
(Date received local registrar) (Registrar's signature)

23. Signature J. E. Davis (M. D. or other)
Address Dexter, Mo. Date signed 7-12-44

RECEIVED

District Health Office No.

District File Number 244-1

Date Filed 8-10-9

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..... Lynnan Steele

Licensed Embalmer No. 2476

P. O. Address Wester N

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.

Registration District No. 341

Primary Registration District No. 3075

Registrar's No. 361

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Nexter, Mo
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Sarah E. Waggoner
3. (b) If veteran, name war _____ 3. (c) Social security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9-17-88
(Month) (Day) (Year)
8. AGE: Years 84 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation Housekeeping

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

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

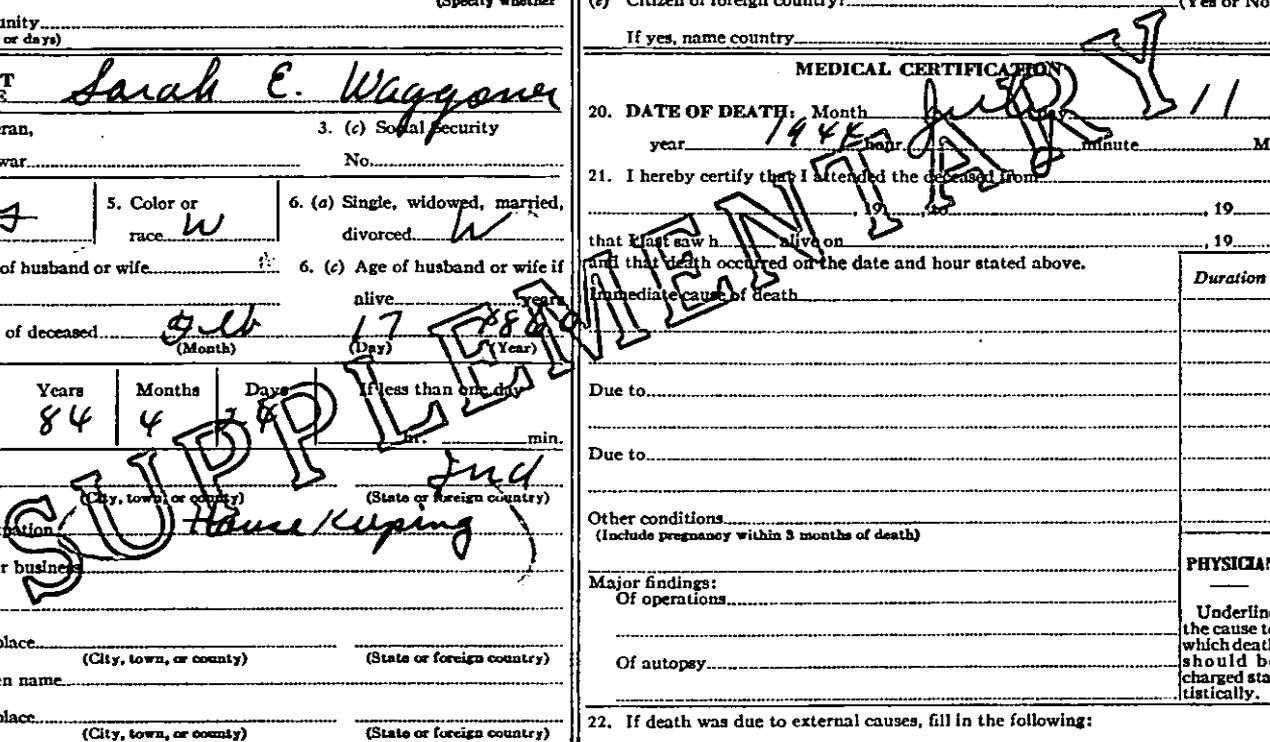
18. (a) Signature of funeral director _____
(b) Address 20.44 Nexter, Mo
19. (a) _____ (b) Nora Smith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July Day 11 year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions _____ (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, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____



MOTHER FATHER

14

25924