

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28199

FILED SEP 16 1944

Registration District No. 1004  
Primary Registration District No. 3038

Registrar's No. 358

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)  
(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 35 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Linn 59  
(c) City or town Brookfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 113 Green  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sadie Sarah Post.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color W. 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Virgil Post 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 24 1866  
(Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Laclede, Mo. (1)  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

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

MOTHER FATHER { 12. Name Joan Waggoner  
13. Birthplace Wagonville, Ia (State or foreign country)  
14. Maiden name Pauline Williams  
15. Birthplace Unknown, Ia (City, town, or county) (State or foreign country)

16. (a) Informant Pauline Kruger

(b) Address 113 Green St Brookfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director James Rowden

(b) Address Brookfield Mo

19. (a) 8-11-1944 (b) M. Cannon  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9  
year 1944 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from Jan 1943  
to Aug 9 1944  
that I last saw him alive on Aug 8 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Dilatation of heart with Fibrillation Duration 1 year

Due to Dont know

Due to \_\_\_\_\_

Other conditions General Anasarca 3 mo  
(Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none  
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 0

23. Signature Mark K. Rhoads (M. D. or other) \_\_\_\_\_

Address Brookfield Mo Date signed 8/11-44

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

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**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.....

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.**