

Registration District No. 50

Primary Registration District No. 5572

1. PLACE OF DEATH

(a) County Jackson  
(b) City or town Rural Prairie Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Jackson County Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 yrs. 9 mo. 21 da  
(Specify whether \_\_\_\_\_)  
In this community 70 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Rural Prairie Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. Jackson County Hospital  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Sarah A Tudor

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. (b) Name of husband or wife

6. (c) Age of husband or wife if alive dead years

7. Birth date of deceased Nov 10 1862  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>11</u>	<u>14</u>	hr. _____ min. _____

9. Birthplace Carroll Co Mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Alexander Skaggs

13. Birthplace no data  
(City, town, or county) (State or foreign country)

14. Maiden name no data

15. Birthplace no data  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert P Tudor

(b) Address Indep. Mo

17. (a) Burial (b) Date thereof 10/27/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem Church Cemetery

18. (a) Signature of funeral director Roland R. Speck

(b) Address Independence, Mo

19. (a) Oct. 25, 1944 (b) F. M. Schickler  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24  
year 1944 hour 8 minute 9 M.

21. I hereby certify that I attended the deceased from 10/26, 1944 to Oct-24, 1944  
that I last saw h alive on Oct 23, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death senility

Due to \_\_\_\_\_  
Due to 162

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 J. H. Greave (M. D. or other) \_\_\_\_\_  
Address Independence Mo Date signed 10/24/44

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

18000

**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 W.B. Langford  
Licensed Embalmer No. 03833  
P. O. Address 1610 Summit St

**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.**