

No. 2
8-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 13 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34891
Registrar's No. 72

Registration District No. 210

Primary Registration District No. 5772

1. PLACE OF DEATH:

(a) County Mercer
(b) City or town Medicine Mound
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community All Her life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Mercer 65
(c) City or town Rural (If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah E. Wendt
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 _____ years
7. Birth date of deceased Dec. 5 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months 9 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation House Keeper

11. Industry or business _____

MOTHER FATHER { 12. Name James Swopes
13. Birthplace Mercer Co. Mo. 0
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Barnes
15. Birthplace Mercer Co. Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Lonnie Wendt
(b) Address Newtown, Mo.

17. (a) Burial (b) Date thereof 10-4-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Half Rock

18. (a) Signature of funeral director Martin Funeral Home
(b) Address Princeton, Mo.

19. (a) 10/3/44 (b) Ivan Martin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2 year 1944 hour 10 minute 45 A.M.
21. I hereby certify that I attended the deceased from Jan 2 1944 to Oct 2 1944; that I last saw her alive on Oct 1 1944 and that death occurred on the date and hour stated above.

Immediate cause of death metastatic Insufficiency of liver Duration 6 weeks
Due to Carcinoma of liver 1 yr.

Due to _____
Other conditions H6
(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? ✓

(Specify type of place) _____
While at work? ✓ (e) Means of injury _____
23. Signature C. L. McClanahan (M. D. or other) MD
Address Luckard, Mo. Date signed 10/3/44

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

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(Licensed Embalmer's Statement on Reverse Side)

