

No. 2  
8-43  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3 8962-A  
Registrar's No. 27

Registration District No. 228

Primary Registration District No. 2074

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

1. PLACE OF DEATH:  
(a) County Scott  
(b) City or town Sikeston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 415 Fletcher St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Scott  
(c) City or town Sikeston  
(If outside city or town limits, write "RURAL")  
(d) Street No. 415 Fletcher (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country —

3. (a) PRINT FULL NAME SARAH JANE MARTIN  
3. (b) If veteran, name war — 3. (c) Social Security No. —

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 8  
year 1944 hour ? minute ? M.  
21. I hereby certify that I attended the deceased from 11-10-44  
19 to Dec visit 19  
that I last saw her alive on 11-10-44  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Henry A. 6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased Jan 16 1875 (Month) (Day) (Year)

Immediate cause of death: Probably coronary thrombosis. Duration

8. AGE: Years 69 Months 10 Days 22 If less than one day hr. min.

Due to —  
Due to —  
Other conditions: Multiple sclerosis. (Include pregnancy within 3 months of death)

9. Birthplace Rose Bud Mo (City, town, or county) (State or foreign country)

10. Usual occupation H. W.

11. Industry or business DK

Major findings: Of operations —  
Of autopsy —  
PHYSICIAN — Underline the cause to which death should be charged statistically.

MOTHER, FATHER

12. Name —

13. Birthplace — (City, town, or county) (State or foreign country)

14. Maiden name Emily Boyd (City, town, or county) (State or foreign country)

15. Birthplace — (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. Martin

(b) Address Sikeston Mo

17. (a) Burial (b) Date thereof 12-10-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Sikeston Mo

18. (a) Signature of funeral director Welch Funeral Home

(b) Address Sikeston Mo

19. (a) 4-3-47 (b) Mrs. J. F. Henry (Date received local registrar) (Registrar's signature)

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 E. D. Hubbard (M. D. or other) M.D.  
Address Sikeston Mo Date signed 12/11/44

RECEIVED

District Health Office No. 2,

District File Number 447-2034

Date Filed 4-9-42

**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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.**