

FILED JAN 2 1945

Registration District No. **348**

Primary Registration District No. **4572**

1. PLACE OF DEATH:

(a) County **Sullivan**
(b) City or town **Newtown**
(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 **about 55 yrs.** years, months or days)

3. (a) PRINT FULL NAME **Sarah Augusta Keith**

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

4. Sex **F** 5. Color or race **X** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Norris N. Keith** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 1876** (Month) (Day) (Year)

8. AGE: Years **68** Months **2** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Penn!** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **DANIAL Porter Myers**
13. Birthplace **Penn. 1** (City, town, or county) (State or foreign country)
14. Maiden name **Strayser**
15. Birthplace **Penn!** (City, town, or county) (State or foreign country)

16. (a) Informant **N. C. Keith**
(b) Address **Harris, Mo.**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Nov 19-44** (Month) (Day) (Year)
(c) Place: burial or cremation **Newtown**

18. (a) Signature of funeral director **Judd Payne**
(b) Address **Newtown**

19. (a) **Dec. 12** (Date received local registrar) (b) **Greta Caldwell** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Sullivan**
(c) City or town **Newtown** (If outside city or town limits, write "RURAL") **10**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **16** year **1944** hour **7 PM** minute _____ M.

21. I hereby certify that I attended the deceased from **Jan 1** 19 **44** to **Nov 16** 19 **44**
that I last saw her alive on **Nov 14** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Essential Hypertension**
Due to **Cerebral hemorrhage**
above

Other conditions (Include pregnancy within 3 months of death) **83A**

Major findings: Of operations _____
Of autopsy _____

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 **A. W. Wade** (M. D. or other) _____
Address **Newtown Mo** Date signed **11-16-44**

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

05
005

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 *T. Howard Guild*
Licensed Embalmer No. *3240*
P. O. Address *Newtown 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.