

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 9 1945

Registration District No. 378

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4652

State File No. 42363

Registrar's No. 122

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Mountain Grove
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether)
In this community Lifetime
years, months or days

3. (a) PRINT FULL NAME SARAH LOUISA CONROW ABSHER

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anderson Absher 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased December 23, 1884
(Month) (Day) (Year)

8. AGE: Years 60 Months - Days - If less than one day
hr. min.

9. Birthplace Hartville, Missouri (City, town, or county) (State or foreign country)
Housewife

10. Usual occupation

11. Industry or business

12. Name Joseph Moore
13. Birthplace Ohio (City, town, or county) (State or foreign country)
14. Maiden name Martha Zeigler
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Katy Conrow
(b) Address Mtn. Grove, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44
(Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director E. J. Barber
(b) Address Mtn. Grove, Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright 114
(c) City or town Mtn. Grove, 1
(If outside city or town limits, write "RURAL") 6
(d) Street No. Wall Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23
year 1944 hour 10:25 minute P. M.

21. I hereby certify that I attended the deceased from 9/12-44, 19, to 12/23-44, 19;
that I last saw her alive on 12/23-44, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma of Liver? Duration

Due to 468

Due to

Other conditions (Include pregnancy within 3 months of death)

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) (c) Means of injury 0

23. Signature R. A. Ryan (M. D. examiner) 12/27
Address Mtn. Grove Mo. Date signed 44

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 *Lawrence L. Hall*

Licensed Embalmer No. *2784*

P. O. Address *Gainesville*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 122

Registration District No. 378

Primary Registration District No. 4562

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Mountain View
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Sarah J. C. Abshe
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 20 1895
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 0 If less than one day _____ hr. _____ min.
9. Birthplace Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 1/16/45 (b) Wm. Rowen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 13 Year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
Duration _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-42363 1944