

3. No. 2
1-8-43
5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3874

FILED FEB 19 1945
Registration District No. 360

Primary Registration District No. 3076

State File No. _____
Registrar's No. 4

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Nevada Center
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Nevada City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 60 yrs (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Vernon
(c) City or town Nevada MO
(If outside city or town limits, write "RURAL")
(d) Street No. 503 E Locust
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah E. Reed
(b) If veteran, name war no
(c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 13
year 1945 hour 6:30 minute A.M.
21. I hereby certify that I attended the deceased from NOV 22, 1944 to Jan 13, 1945
that I last saw her alive on Jan 12, 1945
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 widowed
(b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: May 10, 1870
(Month) (Day) (Year)

Immediate cause of death
Cerebral Hemorrhage
Due to Hypertension
Due to _____
Other conditions (include pregnancy within 3 months of death) none
Major findings: Of operations none
Of autopsy none

8. AGE: Years 74 Months 8 Days 3
If less than one day _____ hr. _____ min.

Duration Dec 14th
Don't know
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace Springfield MO
(City, town, or county) (State or foreign country)
10. Usual occupation Albino wife

MOTHER FATHER
11. Industry or business _____
12. Name Perry Overtaster
13. Birthplace Unknown Miss
(City, town, or county) (State or foreign country)
14. Maiden name Unknown O'Dell
15. Birthplace Unknown Miss
(City, town, or county) (State or foreign country)

16. (a) Informant Ed. Reed
(b) Address Nevada MO
17. (a) Burial (b) Date thereof 1-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Newton Burial Park
18. (a) Signature of funeral director Mark C. Higgins
(b) Address Nevada MO
19. (a) 1-18-45 (b) Hazel B. Beurch
(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? _____
While at work? NO (Specify type of place) (e) Means of injury _____
23. Signature W. H. Love (M. D. or other)
Address Nevada MO Date signed 1/13/45

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

RECEIVED

District Health Officer No. 7,

District File No. 1-45-34

Date filed 2-5-42

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

Mark E. Schuyler

Licensed Embalmer No.

2656

P. O. Address

Nevada, 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.