S. No. 2
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v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

14095

State File No.

Registration District No. 237 Primary Registration District No. 4353 Registrar's No. 2

72
1
0

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Gideon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓ (Specify whether
In this community 42 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Gideon 72
(If outside city or town limits, write "RURAL")

(d) Street No. ✓ 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ✓

3. (a) PRINT FULL NAME Sarah E. Shaw

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 April (Month) 21 (Day) 1859 (Year)

8. AGE: Years 85 Months 8 Days 18 If less than one day ___ hr. ___ min.

9. Birthplace Ohio (City, town, or county) 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ✓

FATHER
12. Name Morris Pyle
13. Birthplace Ohio (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. I. J. Patton
(b) Address Gideon, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. (Month) 11 (Day) 45 (Year)
(c) Place: burial or cremation Mt. Gilead

18. (a) Signature of funeral director Landess Funeral Home
(b) Address Campbell Mo.

19. (a) Jan 11-45 (Date received local registrar) (b) Linda Macom (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9
year 1945 hour 8 minute 45 p.M.

21. I hereby certify that I attended the deceased from Dec 3, 1944, to Jan 9, 1945
that I last saw her alive on Jan 8, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myo Carditis	1 yr
Due to age - Sclerosis of Blood Vessels	
Due to ✓	
Other conditions ✓ (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓ 93	
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 Dr Carlton (M.D. or other)

Address Malden Date signed Jan 10/45

538

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 445-56
Date Filed APR 11 1945

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.....

Licensed Embalmer No.....

P. O. Address.....

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.