

FILED JUN 14 1945

Registration District No. 133

Primary Registration District No. 5483

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Bethany Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
County Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 years
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Sarah Mull

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 Unknown

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Unknown
(Month) (Day) (Year)

8. AGE: Years abt 71 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace: Unknown (City, town, or county) (State or foreign country)

10. Usual occupation: Housework

11. Industry or business _____

12. Name: Unknown

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

14. Maiden name: Unknown

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

16. (a) Informant: Best Nickerson Co Ben

(b) Address: Bethany Mo

17. (a) Co Burial (Burial, cremation, or removal) (b) Date thereof: May 21 1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Co Ben Cemetery

18. (a) Signature of funeral director: Joe E. Wheeler

(b) Address: Bethany Mo

19. (a) May 25 1945 (Date received local registrar) (b) Zola M. Burris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21 year 1945 hour 2 minute A M.

21. I hereby certify that I attended the deceased from Feb 15, 1945, to May 21, 1945; that I last saw her alive on May 15, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis Duration 3 mo

Due to: _____

Due to: _____

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations: _____ 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature: [Signature] (M.D. or other)

Address: Bethany, Mo Date signed: 5-23-45

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

41
60
0

RECEIVED
District Health Officer No. 11
District File Number
Date Filed

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 not
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Joe E. Wheeler
Licensed Embalmer No. 3512
P. O. Address Bethany 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.