

FILED JUL 11 1945
Registration District No. **322**

Primary Registration District No. **4472 3071**

Registrar's No. **10**

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

7
2
1

1. PLACE OF DEATH:

(a) County Saline

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

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no
(Specify whether years, months or days)

In this community no
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Anna Rosie Sinnett

3. (b) If veteran, name war no

3. (c) Social Security No. 486-07-0008

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Oliver Sinnett

6. (c) Age of husband or wife if alive 57
1890

7. Birth date of deceased Nov. (Month) 10 (Day) 1890 (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>54</u>	<u>7</u>	<u>4</u>	hr. min.

9. Birthplace Saline County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

MOTHER FATHER

12. Name Fielding C. Fizer

13. Birthplace Saline County, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Irvonia Hedger

15. Birthplace Saline County Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Oliver Sinnett

(b) Address Slater, Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 6-17-'45
(Month) (Day) (Year)

(c) Place: burial or cremation Slater, Hill Brothers

18. (a) Signature of funeral director Slater Mo.

(b) Address

19. (a) June 16-45 (b) Mrs. John Giger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline **97**

(c) City or town Slater **2**
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th
year 1945 hour 1 minute P M.

21. I hereby certify that I attended the deceased from Mar 10 to June 14, 1945
that I last saw him or her alive on June 14, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency (organic mitral valve)

Duration

Due to

Due to

Other conditions Enlarged left heart, Hypertension
(Include pregnancy within 3 months of death)

Major findings: Stomach disorder vs Shortness of breath

Of operations 92b

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) (c) Means of injury 2

23. Signature R. H. Milledge (M. D. or other) **DO**

Address Slater Mo Date signed 6/15

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

7/10/45

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 _____

Sam M Hill

Licensed Embalmer No. _____

1292

P. O. Address _____

Slater

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.