S. No. 2
M—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 28 1945

State File No. 23711

Registration District No. 61 Primary Registration District No. 5236 Registrar's No. 34

1. PLACE OF DEATH:

(a) County Cedar

(b) City or town El Dorado-Springs Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Box Twp 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Independence 4
(If outside city or town limits, write "RURAL")

(d) Street No. ~~Mason~~ 4
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Emma Anna Saxton

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Female 1

5. Color or race White

6. (a) ~~Single, widowed~~, married, ~~divorced~~ married 1

6. (b) Name of husband or wife Melvin Saxton

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased June (Month) 17 (Day) 1908 (Year)

8. AGE:

Years	Months	Days	If less than one day
37		20	..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Anton Bickel
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Rosa Kettelkake
15. Birthplace Neb (City, town, or county) 1 (State or foreign country)

16. (a) Informant Melvin A Saxton

(b) Address Independence Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/45 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Gwinn Siders

(b) Address El Dorado Springs Mo

19. (a) 7/11/45 (Date received local registrar) (b) L. T. Dunaway (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1945 hour 5 minute 30 P M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....; that I last saw h..... alive on ....., 19....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Accidental Drowning	✓
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) ✓ 20

(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 M D Gwinn Coroner 3 (M.D. or other)

Address El Dorado Springs Mo Date signed 7/10/45

1046

(Licensed Embalmer's Statement on Reverse Side)

JUN 21 1958

RECEIVED
Di... Officer No. 7,
Dis... 6-45-724
Date Filed 7-27-45

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~~ not Embalm... ....., Registered Apprentice No. ....., working under my personal supervision.

Signed O B Sidens

Licensed Embalmer No. 3.250

P. O. Address El Dorado Springs 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.

S. No. 2B
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 449

Registration District No. 61 Primary Registration District No. 5236 Registrar's No. 8

1. PLACE OF DEATH:
(a) County: Cedar
(b) City or town: Rural Box Twp.
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Emma A. Sayten
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: June 17 1898 (Month) (Day) (Year)
8. AGE: Years 37 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Neb. (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1945 hour 4 minute M.
21. I hereby certify that I attended the deceased from , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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): Accident
(b) Date of occurrence: July 7 1945
(c) Where did injury occur? Rural Cedar Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Flood washed car off Highway
While at work? Trip (Specify type of place) (e) Means of injury: Drowning
23. Signature: M D Gwinn (M. D. or other) Coroner
Address: El Dorado Springs Date signed 7-10-45

SUPPLEMENTARY

23711