

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 DEC 7 1945

State File No. 38150

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 324

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bothwell Hospital
(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

3. (a) PRINT NAME NANCY JANE ALEXANDER
FULL NAME

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 S U
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 11 28 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas E. Alexander
13. Birthplace Pettis Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mary E. Hieronymis
15. Birthplace Pettis Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas E. Alexander
(b) Address Sedalia, Mo. RFD # 5
17. (a) Burial (b) Date thereof 12/1/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mem. Park

18. (a) Signature of funeral director Geo. N. Dillard
(b) Address Sedalia
19. (a) 11/30/45 (b) Geo. N. Dillard
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis
(c) City or town Sedalia
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 29
year 1945 hour 5-15 minute A M.

21. I hereby certify that I attended the deceased from 11-28, 1945, to 11-29, 1945.
that I last saw her alive on 11-29, 1945.
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to _____
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) _____
(e) Means of injury _____
3. Signature Geo. N. Dillard (M.D. or other)
Address Sedalia Mo Date signed 11/30/45

(Licensed Embalmer's Statement on Reverse Side)

WHITE EMBALMA—USE PRECEDING BACK INK—HAVE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

RECEIVED

Registration District No. 8

Registration District No. Primary Registration District No.

1. USUAL RESIDENCE OF DECEASED:
(a) State
(b) City or town
(c) Street No.
(d) Citizen of foreign country (Yes or No)
(e) If yes, name country

1. PLACE OF DEATH:
(a) County
(b) City or town
(c) Name of hospital or institution
(d) Length of stay: In hospital or institution
(e) In this community

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month, day, year
21. I hereby certify that I attended the deceased from
that I last saw him alive on
and that death occurred on the date and hour stated above.
Immediate cause of death
Due to
Due to

2. FULL NAME
(a) PRINT
(b) If veteran, name was
(c) Social Security
3. Color or race
4. Sex
5. Name of husband or wife
6. Age of husband or wife
7. Birth date of deceased
8. AGE: Years, Months, Days
If less than one day

STATEMENT BY
PHYSICIAN
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by
Of autopsy
If death was due to external causes, as in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
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.

10. Usual occupation
11. Industry or business
12. Name of business
13. Birthplace
14. Maiden name
15. Birthplace
16. Date of birth
17. Date of death
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