

No. 2  
8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38256**  
Registrar's No. **100**

FILED DEC 12 1945  
Registration District No. **290**

Primary Registration District No. **5986**

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

1. PLACE OF DEATH:  
(a) County **Pulaski**  
(b) City or town **Rural Javerina**  
(c) Name of hospital or institution: **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 **65 years**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Pulaski**  
(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? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Sarah Ann Jabor**  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Oct.** day **30**  
year **1945** hour **Twelve** minute **05 P.** M.

4. Sex **1 F** 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **W 1/2**  
6. (b) Name of husband or wife **Dellwood Jabor**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **August 5 1851**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct. 29**, 1945 to **Oct 30**, 1945  
that I last saw h. or alive on **Oct. 29**, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years **94** Months **2** Days **25**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death **Apoplexia** Duration **2 days**  
Due to **Old age**  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy **g 30**

9. Birthplace **Franklin Co. Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**  
11. Industry or business \_\_\_\_\_  
12. Name **William Joiner**  
13. Birthplace **Tennessee**  
(City, town, or county) (State or foreign country)

14. Maiden name **Lurinda Owens**  
15. Birthplace **Tennessee**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mae Alsop**  
(b) Address **Richland, Mo.**  
17. (a) **Burial** (b) Date thereof **Nov. 1-1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Mount View**  
18. (a) Signature of funeral director **Gene E. Holdren**  
(b) Address **Hartsville, Mo.**  
19. (a) **11-20-1945** (b) **Chas. M. Dodd**  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(c) 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 \_\_\_\_\_  
23. Signature **R. R. Nowlett** (M. D. or other)  
Address **Richland, Mo.** Date signed **10-31-45**

PHYSICIAN  
Underline the cause to which death should be charged statistically.

1170

(Licensed Embalmer's Statement on Reverse Side)

**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 Gene E. Holdren

Licensed Embalmer No. 3865

P. O. Address Hastenville, Ms

**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.**