DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38771

Registration District No. 338 Primary Registration District No. 4501 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Bloomfield Mo
(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
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stoddard 103
(c) City or town Bloomfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Sarah Jane Reese
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 Mary
6. (b) Name of husband or wife James Reese
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	9	18	hr. min.

9. Birthplace Bloomfield Mo (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name J M Baker
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Elizabeth Baker
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Clara Lancaster
(b) Address Bloomfield Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 (Month) (Day) (Year)
(c) Place: burial or cremation Walker Cemetery
18. (a) Signature of funeral director Watkins Funeral Hos
(b) Address Bloomfield Mo
19. (a) 10/29/45 (Date received local registrar) (b) Pearl Elmore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20 year 1945 hour 10 minute 50 a M.
21. I hereby certify that I attended the deceased from Oct. 12, 1945, to Oct. 20, 1945, that I last saw her alive on Oct. 19, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Very of stomach proving cancer.

Due to

Due to

Other conditions: Fraction of lip - [illegible] May 2, 1945 - [illegible]

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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 - fall
(b) Date of occurrence May 2, 1945 103
(c) Where did injury occur? Bloomfield Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place - Walk (Specify type of place)
While at work? (e) Means of injury fractures
23. Signature [illegible] (M.D. or other)
Address Bloomfield Mo Date signed 10/29/45

1130

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1145-3216
Date Filed 11-8-45

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 Lyman Steele

Licensed Embalmer No. 2476

P. O. Address Dexter 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.

No. 2B
M—3-45
I X43880

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

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BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 338 Primary Registration District No. 4501 Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Bloomfield
(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 Sarah J. Reese

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 (Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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 Oct Day 20 year 1945 hour minute 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.

Immediate cause of death — Duration

Due to

Due to

Other conditions Fracture of hip
(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) Accident

(b) Date of occurrence Mar 20 1945

(c) Where did injury occur? Bloomfield Stoddard Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place - sidewalk (Specify type of place)

While at work? No (e) Means of injury Fall

23. Signature John W. Wilson (M. D. or other)

Address Bloomfield, Mo. Date signed 11/20/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

16016

38771