

FILED MAR 29 1946

Registration District No. 331

Primary Registration District No. 4-5-166189

Registrar's No. 70

1. PLACE OF DEATH:

(a) County Taney  
(b) City or town Chestnut Ridge, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Rural near Highway  
(If not in hospital or institution, write street number or location)  
(d) Length of stay in hospital or institution 125  
near County Line  
In this community Several years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Taney  
(c) City or town Chestnut Ridge, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural near the  
County line on Highway 123  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME

Sarah E. Wilson

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 Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 17 1850  
(Month) (Day) (Year)

8. AGE: Years 95 Months 3 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Home work

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name David Wilson  
13. Birthplace don't know  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Brant  
15. Birthplace don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant Earn. Nash

(b) Address Chestnut Ridge Mo.

17. (a) Rural (b) Date thereof Jan 29 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Coff. Cemetery

18. (a) Signature of funeral director T. B. Chaffin

(b) Address Clark Mo.

19. (a) Feb 4 1946 (b) C. R. Allaman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27  
year 1946 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 27 3:00 PM 1946, to Jan 27 11:30 PM 1946 that I last saw her alive on Jan 27 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Flu condition & Heart Failure

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 3/8  
Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(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) (e) Means of injury \_\_\_\_\_

23. Signature J. H. Kado (M. D. or other) \_\_\_\_\_

Address Clark Mo. Date signed Feb 6 1946

RECEIVED  
District Health Officer No. 6,  
District File Number 346-395  
Date Filed MAR 25 1946

STATEMENT BY LICENSED EMBALMER

*was not Embalmed*

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 *T. B. Chaffin*

Licensed Embalmer No. *2192*

P. O. Address *Ozark Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 70

Registration District No. 351

Primary Registration District No. 6189

1. PLACE OF DEATH:

(a) County Jamez  
(b) City or town Jamez  
(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)

3. (a) PRINT FULL NAME

Sarah E. Wilson

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. 5

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

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

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

8. AGE: Years 95 Months 3 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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) Feb 24-46 (b) C. R. Allaman  
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 27  
Year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....;

What I last saw him..... 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.....

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) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

MOTHER, FATHER

11976