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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 15 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23987

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 143

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of ~~hospital or~~ institution: Rest Home
316 S. Fulton 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 Native
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jasper 49
(c) City or town: Carthage 1
(If outside city or town limits, write "RURAL")
(d) Street No. 316 S. Fulton 3
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Mary Olive Sanders
3. (b) If veteran, name war: None
3. (c) Social Security No. None
4. Sex: Female
5. Color or race: W
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Deceased
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: 9 (Month) - 5 (Day) - 1866 (Year)

8. AGE: Years 79 Months 10 Days 21 If less than one day ..... hr. ..... min.

9. Birthplace: Greene Co. (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation: Home 1
11. Industry or business: Housewife
MOTHER FATHER
12. Name: Robert T. Johns
13. Birthplace: Tenn. (City, town, or county) (State or foreign country) 1
14. Maiden name: Sarah E. Wallace
15. Birthplace: Tenn. (City, town, or county) (State or foreign country) 1
16. (a) Informant: Mrs. Stella Cox
(b) Address: Fairview
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-28-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Pleasant Grove
18. (a) Signature of funeral director: Morris Lemon
(b) Address: Miller Mo.
19. (a) 8-5-46 (Date received local registrar) (b) L. B. Clinton M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 26 year 1946 hour 5 minute 15 P.M.
21. I hereby certify that I attended the deceased from July 26, 1946, to July 26, 1946 that I last saw him alive on July 26, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestive Failure	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 94K	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: C. C. Coates (M. D. or other) M.D.
Address: Joplin Mo Date signed 8-8-46

134 (Licensed Embalmer's Statement on Reverse Side)

46-7-631

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 G. R. Leiman

Licensed Embalmer No. 3297

P. O. Address Miller 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.

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STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 143

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(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 (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 Mary O. Sanders

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 5 (Day) 1866 (Year)

8. AGE: Years 79 Months 10 Days 21 If less than one day hr. min.

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

10. Usual occupation at home

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) L. B. Clinton M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug 24 year 1946 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.

	Duration
Immediate cause of death	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

23987