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Rev. 5-17-39  
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34042

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED NOV 3 7 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 3037

Registrar's No. 157

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town McKernon

(c) Name of hospital or institution: Home  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution  
(Specify whether in this community years, months or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

(c) City or town McKernon  
(If outside city or town limits, write "RURAL")

(d) Street No. 412 East Pleasant  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Elizabeth Good

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30<sup>th</sup>  
year 1946 hour 9 minute 45 A.M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced 2

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

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

7. Birth date of deceased May 17 1866  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 27  
1946 to Aug 30 1946

that I last saw her alive on Aug 28 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy

Duration 3 day

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>3</u>	<u>13</u>	hr. _____ min. _____

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

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

9. Birthplace Green Co Missouri  
(City, town, or county) (State or foreign country)

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

10. Usual occupation Housewife

Major findings: 83X

Of operations \_\_\_\_\_

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

12. Name William A. Mills

13. Birthplace Green Co Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Melina Snyder

15. Birthplace Springfield Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Maude Starbuck

(b) Address McKernon, Mo.

17. (a) Burial (b) Date thereof Sept-1-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Summit Cemetery

18. (a) Signature of funeral director H. D. Fossett

(b) Address McKernon Mo.

19. (a) 10/15/46 (b) Ch. Hilbrich  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_

23. Signature P. A. Holmes (M. D. or other) \_\_\_\_\_

Address McKernon Mo Date signed 8-31-46

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

869

RECEIVED

District Health Officer No. 6,

District File Number 1086-1090

Date Filed OCT 31 1946

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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.....

*By me*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Max L. Fossett*

Licensed Embalmer No.....

*4252*

P. O. Address.....

*Mt. Vernon, 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.**