

1. PLACE OF DEATH:

(a) County **Randolph**
(b) City or town **Moberly**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
506 Monroe
(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 **Mary W. Sarbaugh**

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 **Widowed**

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

7. Birth date of deceased **May 31st 1864**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	82	5	23	hr. min.

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

10. Usual occupation **At home**

11. Industry or business _____

12. Name **William Mills**

13. Birthplace **Ky**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **a**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Dixie Henry**

(b) Address **Moberly, Mo.**

17. (a) **Burial** (b) Date thereof **Oct 26th 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Moberly, Mo**

18. (a) Signature of funeral director **Mahaw and Son**

(b) Address **Moberly, Mo**

19. (a) **Oct 26-46** (b) **Paul Williams**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Randolph**
(c) City or town **Moberly**
(If outside city or town limits, write "RURAL")
(d) Street No. **506 Monroe**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **24th**
year **1946** hour **7** minute **45** P.A.M.

21. I hereby certify that I attended the deceased from **2 Oct 1946** to **Oct 24 1946**
that I last saw her alive on **Oct 24 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **apoplexy** Duration **few hrs.**

Due to _____
Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations **83A**

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 **CSmith** (M. D. or other) **6**

Address **Moberly, Mo.** Date signed **Oct 26 46**

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

269

RECEIVED
District Health Officer No. 10
District File Number 10-46-20
Date Filed NOV - 8 1946

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 Frank D. DeWitt
Licensed Embalmer No. 3021
P. O. Address Moberly, 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.

Registration District No. *294*

Primary Registration District No. *3056*

Registrar's No. *217*

1. PLACE OF DEATH:

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

(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 *Mary W. Sarbaugh*

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 *and*

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years *82*

Months

Days

If less than one day

hr. min. *no.*

9. Birthplace _____

(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) _____ (b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *Oct 26 - 76*

(Date received local registrar)

(b) *Leola K. ...*

(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 *Oct* Day *24*
Year *1946* Hour _____ minute _____ M.

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

that I last saw _____ 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:

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(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 _____

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

SUPPLEMENTARY

34489