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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 27 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39298

Registration District No. 323 | Primary Registration District No. 6099 | Registrar's No. 61

1. PLACE OF DEATH:

(a) County: Schuyler

(b) City or town: near Queen City Rural
(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 70 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Schuyler

(c) City or town: Queen City (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: SARAH MARGARET EASON

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: Widow

6. (b) Name of husband or wife: Aaron Eason

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

7. Birth date of deceased: May (Month) 21 (Day) 1869 (Year)

8. AGE: Years 77 | Months 5 | Days 29 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business: " "

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

MOTHER
14. Maiden name: Lavinia Bozell
15. Birthplace: Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant: Lee Eason
(b) Address: Queen City Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 22, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation: Jamtown Cemetery

18. (a) Signature of funeral director: Wm H West
(b) Address: Queen City Mo

19. (a) 11/21/46 (Date received local registrar) (b) Mrs. Ofa Drake (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 19 year 1946 hour 8:45 minute A. M.

21. I hereby certify that I attended the deceased from April 21, 1944 to 11/20, 1946; that I last saw her alive on 11/20, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Arterio-sclerosis	
Due to:	
Other conditions: Diabetes (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy: 61	

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: R. E. Vaughn (M. D. or other) D.O.
Address: Lancaster, Mo. Date signed 11/20/46

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(Licensed Embalmer's Statement on Reverse Side)

JAN 3 1947

RECEIVED
District Health Officer No. 10
District File number 11-46-2191
Date Filed NOV 26 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 Wm N West

Licensed Embalmer No. 5589

P. O. Address Queencity 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.