No. 2
-12-45
-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1565

State File No. _____

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 8

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jane Chinn's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
(c) City or town Webb City 1
(If outside city or town limits, write "RURAL")
(d) Street No. 905 W 3rd 2
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country NO

3. (a) PRINT FULL NAME Sarah Adaline Hendry

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Aug (Month) 10 (Day) 1876 (Year)

8. AGE: Years 70 Months 5 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Jasper County (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

FATHER
12. Name McKinley Morgan
13. Birthplace _____ (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Sarah Waggoner
15. Birthplace _____ (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Wm H. Casey
(b) Address Kansas City Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20 (Month) (Day) 1947 (Year)
(c) Place: burial or cremation Ozark Memorial

18. (a) Signature of funeral director Webb City Und Co
(b) Address Webb City Mo

19. (a) JAN 18; 47 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17 year 1947 hour 6 minute a. M.

21. I hereby certify that I attended the deceased from 10-28, 1946, to 1-17, 1947; that I last saw her alive on 1-16, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to _____

Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

93D

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) 2
While at work? _____ (e) Means of injury _____

23. Signature [illegible] (M. D. or other) DO
Address Webb City, Mo Date signed 1/18/47

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(Licensed Embalmer's Statement on Reverse Side)

47-1-18

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 Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address West Bety 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.