

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 5 1947
Registration District No. 314

Primary Registration District No. 6273

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Grant City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 90 yrs (Specify whether years, months or days)
In this community 90 yrs

3. (a) PRINT FULL NAME

Sarah Elizabeth Waugh

3. (b) If veteran,

name war.....

3. (c) Social Security

No.....

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife William Waugh
6. (c) Age of husband or wife if alive 1854 years
7. Birth date of deceased March 22 (Month) (Day) (Year)

8. AGE: Years 92 Months 9 Days 26 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Joe H. Waugh

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

14. Maiden name James H. Waugh

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

16. (a) Informant Carl H. Waugh

(b) Address Poplar, Mo.

17. (a) Burial (b) Date thereof 1-23-47 (Month) (Day) (Year)

(c) Place: burial or cremation Midvale

18. (a) Signature of funeral director John C. Duffee

(b) Address Grant City, Mo.

19. (a) 1-24-47 (b) Letta E. Dawson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Worth
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Grant City, Mo. (If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 18 year 1947 hour 3 minute 05 P.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.

Immediate cause of death Old age complicated by heart failure Duration short

Natural cause

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

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 fall

23. Signature John C. Duffee (M.D. or other) Grant City, Mo.

Address Grant City, Mo. Date signed 1-22-47

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Arch C. Dwyer*.....
Licensed Embalmer No. *3252*.....
P. O. Address *Grant City, 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.