S. No. 2
OM—5-43
v. 5-17-39
o 1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1947

Registration District No. 7

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3865

Primary Registration District No. 4020

Registrar's No.

1. PLACE OF DEATH:

(a) County Audrain

(b) City or town Martinsburg 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 (Specify whether
In this community 11 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain 4

(c) City or town Martinsburg Mo. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Sara O:Meara

3. (b) If veteran, name war "

3. (c) Social Security No. "

4. Sex Female 1

5. Color or race White

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

6. (b) Name of husband or wife "

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

7. Birth date of deceased Sept (Month) 5 (Day) 1865 (Year)

8. AGE:

Years	Months	Days	If less than one day
81	5	19	hr. min.

9. Birthplace (City, town, or county) Ohio 1 (State or foreign country)

10. Usual occupation AT home

11. Industry or business Same

FATHER
12. Name Patrick O:Meara
13. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Ellen Healey
15. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant Mrs Francis O:Meara 1

(b) Address Martinsburg Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/47/ (Month) (Day) (Year)

(c) Place: burial or cremation Glenwood Mo

18. (a) Signature of funeral director K. B. Wells

(b) Address Wellsville Mo

19. (a) 2-28-47 (Date received local registrar) (b) Mrs. Joe Carter (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 2 day 24
year 1947 hour 11 minute 30 p.M.

21. I hereby certify that I attended the deceased from Jan 24, 1947 to Feb 24, 1947
that I last saw her alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage — Duration 1 hour

Due to hypertension —

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?
(Specify type of place)

While at work (e) Means of injury 0

23. Signature [signature] (M. D. or other)

Address Wellsville Mo Date signed 3/26/47

(Licensed Embalmer's Statement on Reverse Side)

MAR 25 1947

APR 1 1941

RECEIVED
District Health Officer No. 10
MAR 11 1947

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~~ Self,

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

working under my personal supervision.

Signed R B Keller

Licensed Embalmer No. 1588

P. O. Address Willsville 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.