

FILED APR 23 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13118**

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **333**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. John's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 days** (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME

Jack W. Sarantta

3. (b) If veteran name war

3. (c) Social Security No.

4. Sex **Male** 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: **1872** **Feb**
(Month) (Day) (Year)

8. AGE: Years **75** Months **1** Days **18**
If less than one day hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Wilburn Sarantta**
(b) Address **Salina Mo**

17. (a) **Removal** (b) Date thereof **4-8-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Willgo cemetery**

18. (a) Signature of funeral director **Raymond M. Moore**
(b) Address **Salina Mo**

19. (a) **4-8-47** (b) **W. J. Handley M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Benton**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Flat Creek Sarantta**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **8**
year **1947** hour **8** minute **20 AM**

21. I hereby certify that I attended the deceased from **2 April 1947** to **7 April 1947**
that I last saw him alive on **6 April 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Post-operative shock**
Due to **trans-urethral prostatic resection**

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations **prostate**
Of autopsy

Duration

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 **W. J. Handley** (M. D. or other)
Address **200 E. Sprague** Date signed **April 9**

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

19
2
6

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 *Henry H. Mauler*
Licensed Embalmer No. *3827*
P. O. Address *Strom, 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.