S. No. 2
M-8-43
5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 18 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16050

Registration District No. 32 Primary Registration District No. 3071 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Slater (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 430 North Main St (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 79 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline
(c) City or town Slater (If outside city or town limits, write "RURAL")
(d) Street No. 430 N Main St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah Frances Allen
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 Widowed
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August 2 1854 (Month) (Day) (Year)
8. AGE: Years 92 Months 7 Days 21 If less than one day hr. min.
9. Birthplace Franklin Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
FATHER 12. Name Andrew Watson Bridges
13. Birthplace Virginia (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Eliza Smith Brodley
15. Birthplace Don't Know (City, town, or county) (State or foreign country)
16. (a) Informant Mrs E J [illegible]
(b) Address Slater Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-47 (Month) (Day) (Year)
(c) Place: burial or cremation Slater City Cemetery
18. (a) Signature of funeral director Jones & Gaza
(b) Address Slater Mo
19. (a) Mar. 31, 1947 (Date received local registrar) (b) Mrs Earl C. Metz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23 year 1947 hour 8 minute 25 P M.
21. I hereby certify that I attended the deceased from Jan 23 1947 to March 23 1947
that I last saw her alive on March 23 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardial failure	1 mo
Due to Fractured neck of femur	2 mo
Due to Decubitus - infected area	1½ mo

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations Of autopsy

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

SUPPLEMENTAL INFORMATION REQUESTED

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 C. A. McBurney M.D. (M. D. or other)
Address Slater Mo Date signed 3/25/47

292 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 4-7-47

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 _____

Licensed Embalmer No. 3143

P. O. Address Slaton Tx

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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 322 Primary Registration District No. 3071 Registrar's No.

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Slater
(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
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah F. Allen
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased Aug 2 1854 (Month) (Day) (Year)
8. AGE: Years 92 Months Days If less than one day hr. min.
9. Birthplace (City, town or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 23 year 1947 at hour minute 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 — *Duration*
Due to Fell getting out of a chair in home
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
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) Accident
(b) Date of occurrence January 27 1947
(c) Where did injury occur? Home Slater Saline Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? no (e) Means of injury Fall

23. Signature O. A. McBurney (M. D. or other)
Address Slater Date signed 5-9-47

SUPPLEMENTARY

160050