

FILED JUL 7 1947

Registration District No. 201

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3048

State File No. 21770

Registrar's No. 132

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

1. PLACE OF DEATH:

(a) County Nodaway
(b) City or town Maryville, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
512 Prather Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 22 Years
years, months or days)

3. (a) PRINT FULL NAME SARAH MOLINDA HAGAN

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 Married

6. (b) Name of husband or wife S. G. Hagan 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased January 30, 1870
(Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 22
If less than one day hr. - - - min.

9. Birthplace Urbana Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name Samuel Thornton

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

14. Maiden name Periba York

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

16. (a) Informant S. G. Hagan
(b) Address Maryville, Mo.

17. (a) Burial (b) Date thereof 6/24/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Barnard, Mo.
18. (a) Signature Prue Funeral home
(b) Address 120 E. 1st, Maryville, Mo.

19. (a) 6-24-1947 (b) Bess Holt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway
(c) City or town Maryville
(If outside city or town limits, write "RURAL")
(d) Street No. 512 Prather Ave.,
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22nd.
year 1947 hour 10 minut 30 P. M.

21. I hereby certify that I attended the deceased from JUNE 9, 1947 to JUNE 22, 1947;
that I last saw her alive on JUNE 22, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY THROMBOSIS
Duration 12 HRS.

Due to CORONARY ARTERITIS
Due to _____

Other conditions (Include pregnancy within 3 months of death) 99

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) _____
(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 2

23. Signature W. L. Sandhath (M. D. or other) DO
Address MARYVILLE Mo. Date signed 6-24-47

DISTRICT HEALTH OFFICE
Canton, 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.....

W. L. Gee

Licensed Embalmer No.....

2539

P. O. Address.....

Marquille, 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.