

U. S. No. 2
FORM-5-43
Rev. 5-17-39
No. I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28700**

FILED SEP 9 1947

Registration District No. **294**

Primary Registration District No. **6008**

Registrar's No. **199**

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

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Prairie Township
(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 _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Prairie Township
(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 Alice S. Davis

3. (b) If veteran, name war. ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2nd
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug 1
1947 to Sept 2, 1947
that I last saw her alive on Sept 1, 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased: May 15th 1864
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis, Sudden

Duration _____

Due to _____

Due to _____

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>3</u>	<u>17</u>	hr. _____ min. _____

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.

9. Birthplace Mo. c
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER

12. Name John Sorrell

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

14. Maiden name Alice Cameron

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

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 He Guy Beth (M. D. or other) _____
Address _____ Date signed 9/2/47

16. (a) Informant Frank Davis

(b) Address Renick Mo RFD

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

(c) Place: burial or cremation New Hope

18. (a) Signature of funeral director Mahan and Son

(b) Address P. Moberly Mo

19. (a) Sept 4-47 (b) Leah Sullivan
(Date received local registrar) (Registrar's signature)

RECEIVED
District Health Officer No. 10
District File Number 9-47-1206
Date Filed SEP-8-1947

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Frank D D'Witt

Licensed Embalmer No. 3021

P. O. Address Moberly 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.