

No. 2
-12-45
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 20 1947

THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 287779

Registration District No. 316

Primary Registration District No. 3061

Registrar's No. 274

WRITE PLAINLY—USE UNFADING BLACK INK—MOTHER FATHER

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Flat River mo
(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 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Sarah Lince

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 widow

6. (b) Name of husband or wife Joseph Lince 6. (c) Age of husband or wife if alive 100 1/2 years

7. Birth date of deceased Oct 11 1878
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Iron Co. mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Elige Smith

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

14. Maiden name Malinda Gounds

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

16. (a) Informant W. M. Lince

(b) Address Flat River mo

17. (a) Burial (b) Date thereof 6-16-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Baldwell Bro

(b) Address Flat River mo

19. (a) 8-15-47 (b) Ether Kudloff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Flat River mo
(If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13 day June
year 1947 hour 9:00 minute 0 M.

21. I hereby certify that I attended the deceased from June 11, 1947 to June 13, 1947
that I last saw her alive on June 13, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac
Terminal Pneumonia 100%

Due to Cardiac Dilatation &

Due to Hypertrophy 56 yrs

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

Major findings: 95%
Of operations _____

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 0

23. Signature H. C. Shepherd (M. D. or other)

Address Flat River mo Date signed 8-9-47

RECEIVED

Health Officer No. 4

Number 847-107

8-19-47

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 W.A. Baldwin

Licensed Embalmer No. 3317

P. O. Address Flat River 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.