

S. No. 2  
1-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED SEP 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30323**  
Registrar's No. **30323**

Registration District No. **30** Primary Registration District No. **4038**

1. PLACE OF DEATH:  
(a) County **Benton**  
(b) City or town **Warsaw**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **None**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. **Life** (Specify whether  
In this community **Life** years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Benton**  
(c) City or town **Warsaw**  
(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.

3. (a) PRINT FULL NAME **SARAH ELIZABETH SAPP**  
3. (b) If veteran, name war. **NO**  
3. (c) Social Security No. **NO**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept** day **19**  
year **1947** hour **1** minute **15 P.M.**

4. Sex **Female** 5. Color or race **W**  
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 **Nov 10 1861**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9-18**  
**57** to **9-19-1947**  
that I last saw him alive on **9-18-1947**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**85 10 9** hr. min.

Immediate cause of death **Cerebral Apoplexy - Hemorrhage**  
Due to  
Due to

9. Birthplace **Montgomery County MO**  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**

Major findings: Of operations **GBA**  
Of autopsy  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

11. Industry or business **Home**

12. Name **William Wilson**  
13. Birthplace **MO**  
(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 **Loren Bailey**  
(b) Address **Warsaw Mo.**

17. (a) **Burial** (b) Date thereof **9-23-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director **Riverside**  
(b) Address **Riverside Funeral Home**

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?

19. (a) **9/26/47** (b) **Geo. D. Logan**  
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place)  
(c) Means of injury  
23. Signature **Helstrut** (M. D. or other)  
Address Date signed **9/26/47**

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

RECEIVED  
District Health Officer No. 7,  
8-47-48  
Date: 9-29-47

**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..... *John F. Reser*  
Licensed Embalmer No. *4099*  
P. O. Address..... *Warsaw*

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.