

Registration District No. ....

Primary Registration District No. **5003 3000**

**1. PLACE OF DEATH:**  
 (a) County Adair  
 (b) City or town Ricksville  
(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 Life  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Adair  
 (c) City or town Rural Whitleys Point  
(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** CINDERELLA JANE SANDERS  
 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 WIDOWED  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: 9 / 1 / 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>2</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Jack Young

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

14. Maiden name Armanda Braden

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

16. (a) Informant Ona Hollowell

(b) Address Wartington Mo

17. (a) Burial (b) Date thereof: 11-9-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Grove

18. (a) Signature of funeral director Henry E. Hunt & Son

(b) Address Green City Mo  
 19. (a) 11-17-47 (b) Kate Lambert  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month 11 day 7  
 year 1947 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 10/6 to 11/7, 1947, that I last saw her alive on 11/7, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic  
Glomerular Nephritis

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
131B

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 W. H. Summers (M. D. or other) \_\_\_\_\_  
 Address Ricksville Mo Date signed 11/12/47

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

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

RECEIVED  
District Health Officer No. 10  
District File Number 11-47-1622  
Date Filed NOV 26 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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.