

S. No. 2  
M-5-43  
5-17-39  
X15571

FILED JAN 29 1948

Registration District No. 338

Primary Registration District No. 6148

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Bloomfield, Route 1. Rural  
(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 \_\_\_\_\_  
(Specify whether years, months or days)

In this community Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard / 03

(c) City or town Rural  
(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 M. MC FERRON

3. (b) If veteran, name war --

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20th  
year 1947 hour 2:15 P.M. minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from January 1, 1947 to Dec 18, 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 Deceased 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 1, 1860  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Chronic Myocarditis ?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>9</u>	<u>19</u>	_____ hr. _____ min.

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: None performed

Of operations \_\_\_\_\_

Of autopsy None performed

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

10. Usual occupation Housewife

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? \_\_\_\_\_

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

12. Name J. P. Ancell

13. Birthplace Not known  
(City, town, or county) (State or foreign country)

14. Maiden name Clark

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

16. (a) Informant Ralph Mc Ferron

(b) Address Bloomfield, Mo. Route # 1

17. (a) Burial  
(Burial, cremation, or removal) (b) Date thereof Dec. 22-47  
(Month) (Day) (Year)

(c) Place: burial or cremation North Antioch

While at work? \_\_\_\_\_  
(Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) Mal  
Address Bloomfield Mo Date signed 1-10-48

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) Jan 23, 1948 (b) [Signature]  
(Date received local registrar) (Registrar's signature) 255

RECEIVED  
District Health Office No. 2,  
District File Number 148-134  
Date Filed 1-26-48

---

---

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..... No Embalming.  
Licensed Embalmer No.....  
P. O. Address.....

**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.**