

No. 2  
-5-43  
-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 13 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 498

Registration District No. Primary Registration District No. 4084 Registrar's No. 2

1. PLACE OF DEATH:  
(a) County **Carroll**  
(b) City or town **Wakenda**  
(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 **Entire Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **Carroll** / 7  
(c) City or town **Wakenda** 0  
(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 **SARAH MATILDA PENCE**

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex **Fe.** / 5. Color of race **W.** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **A.B. Pence** 6. (c) Age of husband or wife if alive years

7. Birth date of deceased **Dec. 26 1967**  
(Month) (Day) (Year)

8. AGE: Years 80 Months 0 Days 7 If less than one day hr. min.

9. Birthplace **Carroll County Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

12. Name **James Haskins**

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

14. Maiden name **Florinda Winfrey**

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

16. (a) Informant **Ledrew Pence**  
(b) Address **Carrollton, Mo.**

17. (a) **Burial** (b) Date thereof **1/4/1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cem.**

18. (a) Signature of funeral director **Standley & Gibson**

(b) Address **Carrollton, Mo.**

19. (a) **Jan 6-48** (b) **Pearl Koch**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **2**  
year **1948** hour **1** minute **55 P. M.**

21. I hereby certify that I attended the deceased from **Nov. 15,**  
**1947**, to **Jan 2,** 19**48**  
that I last saw her alive on **Jan 1,** 19**48**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral atrophy of heart** Duration **2 min**

Due to **Myocardial Degeneration** **4 yrs**

Due to

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.

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?

(Specify type of place) (e) Means of injury

23. Signature **Dr. Conrad L. Smith** (M. D. or other) **MS**

Address **111 S. Main Carrollton, Mo.** Date signed **1-7-48**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

1-12-48

Date Filed

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 Ben W Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton 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.