No. 2
2-45
-39
47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 10 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11871

Registration District No. 91 Primary Registration District No. 3012 Registrar's No. 56

1. PLACE OF DEATH:

(a) County CLAY

(b) City or town EXCELSIOR SPRINGS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 718 HAZEL ST.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NEITHER (Specify whether
In this community 27 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY 24

(c) City or town EXCELSIOR SPRINGS 1
(If outside city or town limits, write "RURAL")

(d) Street No. 718 HAZEL STREET 1
(If rural, give location)

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

If yes, name country — 0

3. (a) PRINT FULL NAME SARAH KATHERINE McKOWN

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex 1 FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or wife DAVID C. McKOWN

6. (c) Age of husband or wife if alive DECEASED years

7. Birth date of deceased FEB. (Month) 11 (Day) 1850 (Year)

8. AGE: Years 98 Months 2 Days 10 If less than one day ___ hr. ___ min.

9. Birthplace RAY COUNTY (City, town, or county) 0 MISSOURI (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business NONE

FATHER
12. Name UNKNOWN 9
13. Birthplace UNKNOWN (City, town, or county) UNKNOWN (State or foreign country)

MOTHER
14. Maiden name ANN VANDERPOOL 9
15. Birthplace UNKNOWN (City, town, or county) UNKNOWN (State or foreign country)

16. (a) Informant John McKown
(b) Address Excelsior Springs, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 23, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation OLD UNION CEMETERY

18. (a) Signature of funeral director Claude Prichard
(b) Address Excelsior Springs, Mo.

19. (a) 4/23/48 (Date received local registrar) (b) Caroline Hutchings (Registrar's signature) 1 2 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 21
year 1948 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from 4-20, 1948, to 4-21, 1948
that I last saw her alive on 4-21-, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction

Due to Vascular dis Edge

Due to Senility

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

Major findings:
Of operations 1 2 B

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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature J. E. Boers M.D. (M.D. or other)

Address Excelsior Springs Date signed 4-22-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number.....

Date Filed 5-8-48

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 Lindell K. Jarman, Registered Apprentice No. 88 working under my personal supervision.

Signed E. E. White

Licensed Embalmer No. 468

P. O. Address Ex. Spgs., 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.

No. 2B.
1—3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 21 Primary Registration District No. 3012 Registrar's No. 56

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Nelson Springs
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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 K. McKown

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 Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

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

8. AGE: Years 98 Months 2 Days 14 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 21 year 1944 hour 10 minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to Permission for autopsy could not be obtained, therefore cause of intestional obstruction is not known.

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)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-11871