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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
**FILED JUN 24 1948**

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

**20004**

State File No. \_\_\_\_\_  
Registrar's No. 14

Registration District No. 177

Primary Registration District No. 5638

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

**1. PLACE OF DEATH:**

(a) County Lafayette

(b) City or town Rural Sniabar Twne.  
(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 45 Yrs. years, months or days

**3. (a) PRINT FULL NAME** Jennie T. Null

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

4. Sex Fe/ 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Sam S. Null 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 4, 1852  
(Month) (Day) (Year)

**8. AGE:** Years 95 Months 6 Days 27 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Campbell Co. Virginia  
(City, town, or county) (State or foreign country)

10. Usual occupation At home

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

12. Name John A. West

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

14. Maiden name California East

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

16. (a) Informant Mrs. Kate Riley

(b) Address Odessa, Mo.

17. (a) Burial (b) Date thereof June 3, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Odessa, Mo. Cem.

18. (a) Signature of funeral director Husman-Sparks

(b) Address Odessa, Mo.

June 3 '48 (Date received local registrar) \_\_\_\_\_ (Registrar's signature) \_\_\_\_\_

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Lafayette

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 4 Mi. SE of Odessa  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 1, year 1948 hour 7 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from May 18, 1948 to May 27, 1948; that I last saw her alive on May 27, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Prigemious Hypertension

Due to Senility

Due to Apoplexy + paralysis of left side.

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
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? \_\_\_\_\_

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed [Date]

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-23-48

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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 William T. Sparks

Licensed Embalmer No. # 4431

P. O. Address Odessa, 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.**