

FILED JUN 30 1948

State File No. _____

Registration District No. _____

Primary Registration District No. 5725

Registrar's No. 340

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural Hudson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Hedreth Sanctorium in O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Just a day
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Sarah Kaden

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

4. Sex F 5. Color of face W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Henry Kaden 6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased Jan 3, 1875
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name David Sherman
13. Birthplace Lewis Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Waterman
15. Birthplace Lewis County Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lester Jolins
(b) Address Lewis Co Mo

17. (a) removal (b) Date thereof 6-9-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Jude's Cyp - rural city

18. (a) Signature of funeral director Albert Hennes
(b) Address Macon Mo

19. (a) 6/24/48 (b) W. H. McNeely
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lewis Co
(c) City or town Palmyra
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1948 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from May 28, 1948, to June 9, 1948
that I last saw her alive on June 9, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death

Apoplexy

Duration

36 hours

Due to _____

Due to _____

Other conditions Cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy BA

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 2

23. Signature W. H. McNeely (M. D. or other) _____
Address Macon Date June 9 48

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

JAN 9 1950

RECEIVED

District Health Officer No. 10

District File Number 6-48-1143

Date Filed JUN 29 1948

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 Albert Skinner

Licensed Embalmer No. 707

P. O. Address Macon 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.

Registration District No. 200

Primary Registration District No. 5725

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural
(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 _____ years, months or days)

3. (a) PRINT FULL NAME

Sarah Kadem

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 m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

(Month) Jan

(Day) _____

(Year) _____

8. AGE:

Years

Months

Days

If less than one day

73

hr. _____ min. _____

9. Birthplace _____

(City, town, or county)

(State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lewis

(c) City or town Palmyna Mo.
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

5-20120