

No. 2
1/47
17-39

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

22650

State File No.

National Office of Vital Statistics
FILED JUL 23 1948

Registrar's No. 90

Registration District No.

Primary Registration District No. 5310

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

1. PLACE OF DEATH:

(a) County Cooper

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

(c) Name of hospital or institution At Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 70 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

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

(d) Street No. Rural
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Sarah Lillian Hull

3. (b) If veteran, name war.

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1948 hour 5 minute p. M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Chas. G. Hull

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased August 19 1872
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-2 1948 to 7-12 1948
that I last saw her alive on 7-12 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion
Duration 1 day

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>10</u>	<u>23</u>hr.min.

Due to Pernicious Anemia 4 yrs

9. Birthplace Taberville, St. Claire County, Mo.
(City, town, or county) (State or foreign country)

Other conditions unhealed fracture 1 year
(Include pregnancy within 3 months of death)
loss femur

10. Usual occupation Housewife

PHYSICIAN gyp

Underline the cause of which death should be charged statistically.

11. Industry or business At home

12. Name Joseph ASHMEAD

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

14. Maiden name Mary Ann Aldredge

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

16. (a) Informant W. S. Hull

(b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof July 14ⁿ/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pilot Grove Mo.

18. (a) Signature of funeral director Goodman & Boller

(b) Address Boonville, Mo.

19. (a) 7-14-48 (b) De Cooper
(Date received local registrar) (Registrar's signature)

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?

(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 U

23. Signature W. S. Hull (M. D. or other) MD

Address Boonville Mo Date signed 7-14-48

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

7-22-48

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. 480
working under my personal supervision.

Signed.....

J. H. Goodman

Licensed Embalmer No. 1178

P. O. Address

Beaverville, 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.