

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25330**

FILED SEP 1 1948

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **251**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirkville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Laughlin**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **18 days**
In this community **Life** years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Sarah Elizabeth Myers**

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 **Married**

(b) Name of husband or wife **D. C. Myers** 6. (c) Age of husband or wife if alive **82** years

7. Birth date of deceased **March 3, 1873**
(Month) (Day) (Year)

8. AGE: Years **75** Months **5** Days **16**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **James H. Novinger**

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

14. Maiden name **Elizabeth Shopp**

15. Birthplace **Daulphin Co., Pa.**
(City, town, or county) (State or foreign country)

16. (a) Informant **D. C. Myers**

(b) Address **Green City, Mo.**

17. (a) **Burial** (b) Date thereof **8/22/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet**

18. (a) Signature of funeral director **W. E. Hunt**
(b) Address **Green City, Mo.**

19. (a) **8-23-48** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Sullivan**
(c) City or town **Green City**
(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 **August** day **19**
year **1948** hour **10** minute **40 AM.**

21. I hereby certify that I attended the deceased from **August 2**, 19**48** to **August 19**, 19**48**
that I last saw her alive on **August 18**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Embolism**
Duration _____

Due to _____

Due to _____

Other conditions **Anxiety Neurosis**
(Include progress within 3 months of death) **Hypertension**

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 **P. J. Woods** (M.D. or other) _____
Address **Kirkville, Mo.** Date signed _____

Aug 19, 1948

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

MOTHER FATHER

OCT 8 1952

JAN 29 1951

MAY 23 1951

RECEIVED

District Health Officer No.

District File Number 8-48-1

Date Filed AUG 31 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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City 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.