

FILED SEP 2 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25465

Registration District No. 38

Primary Registration District No. 3006

State File No. \_\_\_\_\_

Registrar's No. 227

## 1. PLACE OF DEATH:

(a) County Boone  
 (b) City or town Columbia  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Sanford's Convalescent Home  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 26 days (Specify whether  
 In this community about 25 yrs (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME NORA SEXTON

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced widow  
 6. (b) Name of husband or wife Brown Sexton 6. (c) Age of husband or wife if alive 1882 years  
 7. Birth date of deceased 2-4-1882  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 6 15 hr. min.9. Birthplace Howard Mo MO  
(City, town, or county) (State or foreign country)10. Usual occupation at home

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

MOTHER FATHER { 12. Name Unknown 9

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

14. Maiden name Unknown 7

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

16. (a) Informant C. H. Dulle(b) Address Jefferson City Mo.17. (a) Burial (b) Date thereof 8-22-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Hinton Mo18. (a) Signature of funeral director Stuart P. Parker(b) Address Columbia, Missouri19. (a) 8-23-48 (b) Mrs. R. E. Palmer  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10  
 (c) City or town Columbia 2  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 117 N. 6th St. 4  
 (If rural, give location) 0  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 19  
year 48 hour 8 minute 0 M.21. I hereby certify that I attended the deceased from 7-16-  
1948 to 8-19-1948  
that I last saw him alive on 7-16-1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Urbilical Hernia Operated Duration all his life  
About 3 yrs ago  
 Due to I sent him to Bruce Co. Mo. for about  
a wk. latter part  
of July.  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: Urbilical Hernia PHYSICIAN \_\_\_\_\_Of operations \_\_\_\_\_ Underline the cause to which death should be charged statistically.  
Of autopsy None

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(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? No (Specify type of place) (e) Means of injury \_\_\_\_\_23. Signature W. D. Byxort (M. D. or other) M.D.Address Columbia Mo Date signed 8-28-48

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed SEP 1 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

working under my personal supervision.

Registered Apprentice No.

Signed

Licensed Embalmer No.

P. O. Address

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.