S. No. 2
M—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30487

FILED SEP 25 1948

Registration District No. 42

Primary Registration District No. 4362

Registrar's No. 54

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Morehouse (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 43 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County NewMadrid 12

(c) City or town More house (If outside city or town limits, write "RURAL") 3

(d) Street No. (If rural, give location) 0

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sibble Augusta Thomann

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Joseph A. Thomann

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

7. Birth date of deceased May (Month) 2 (Day) 1856 (Year)

8. AGE:	Years	Months	Days	If less than one day
	92	4	12	hr. min.

9. Birthplace Dark Co. (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name ---- Ehrhart
13. Birthplace Don't know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Don't know
15. Birthplace Don't know (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rosa Morse

(b) Address Morehouse Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-48 (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director Watkins Funeral Ser.

(b) Address Dexter, Mo.

19. (a) Sept. 21-1948 (Date received local registrar) (b) Thomas Sheeter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 14 year 1948 hour 7 minute 40 a.M.

21. I hereby certify that I attended the deceased from 9-1-48, 19..., to 9-14, 1948; that I last saw her alive on 9-14, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature S. M. Sarno MD (M. D. or other)

Address Morehouse Mo. Date signed 9-15-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File Number 948-12
Date Filed 9-22-4

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 Walter Marsh Watkins Registered Apprentice No. 255 working under my personal supervision.

Signed Lyman Steele
Licensed Embalmer No. 2476
P. O. Address Dexter 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.

S. No. 2B
M—3-45
IX43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 242 Primary Registration District No. 4362 Registrar's No. 56

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Morehouse
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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

3. (a) PRINT FULL NAME Sibble A. Thomann

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased May 2 (Month) (Day) (Year)

8. AGE: Years 92 Months 4 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 4 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

1948
5-30487