

S. No. 300
DM-10-47
Rev. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39460**

FILED DEC 27 1948

Registration District No. **42**

Primary Registration District No. **5129**

Registrar's No. **1372**

1. PLACE OF DEATH:

(a) County **Buchanan**

(b) City or town **Gower "Rural"**
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution **None**
(Specify whether)

In this community **All Life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Buchanan** **11**

(c) City or town **Gower Rural** **0**
(If outside city or town limits, write "RURAL")

(d) Street No. **3**
(If rural, give location) **3**

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

If yes, name country _____

3. (a) PRINT FULL NAME **SARAH M. WITT**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **20**
year **1948** hour **1:10** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **12-19**
1948, to **12-19**, 19**48**
that I last saw her alive on **12-19**, 19**48**
and that death occurred on the date and hour stated above.

4. Sex **Female**

5. Color or race **White**

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

6. (b) Name of husband or wife **Single**

6. (c) Age of husband or wife if alive **None** years

7. Birth date of deceased: **Sept. 22 1870**
(Month) (Day) (Year)

Immediate cause of death
Cerebral apoplexy **1 1/2 hr**

Due to _____

Due to _____

8. AGE: Years **78** Months **2** Days **28**

If less than one day
hr. _____ min. _____

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.

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

10. Usual occupation **House Keeping**

11. Industry or business **House Keeping**

12. Name **Alexander J. Witt**

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

14. Maiden name **Sarah E. Cummins**

15. Birthplace **Gower Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Arthur M. Witt**

(b) Address **Gower Mo**

17. (a) **Burial** (b) Date thereof **Dec. 24-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Gower, Allen Cem.**

18. (a) Signature of funeral director **John K. Murray**

(b) Address **Gower, Mo.**

19. (a) **12-23-48** (b) **G. C. Jenkins**
(Date received local registrar) (Registrar's signature) **382**

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 **0**

23. Signature **J. C. Starks** (M. D. or other) _____
Address **Gower, Mo** Date signed **12-20-48**

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

11
0
0

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 Me

....., Registered Apprentice No.....
working under my personal supervision.

Signed

John H. Murray

Licensed Embalmer No.

2893

P. O. Address.

Gower, 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.