

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42214

Registration District No. 314 Primary Registration District No. 6157 Registrar's No.

1. PLACE OF DEATH:
(a) County Stone
(b) City or town Rural Pt 1
(c) Name of hospital or institution: 9 miles north Berryville, Ark.
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stone 104
(c) City or town Rural Pt 1
(d) Street No. 9 mi. north Berryville, Ark.
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME SARAH M. HAYNES

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. married

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

7. Birth date of deceased April 22 1875 (Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 20 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name George High

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

14. Maiden name Elizabeth Stanley

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

16. (a) Informant Bert Haynes (b) Address Rt 1, Berryville, Ark.

17. (a) Burial, cremation, or removal Rural (b) Date thereof Dec 13 1948 (Month) (Day) (Year)

(c) Place: burial or cremation High Cemetery

18. (a) Signature of funeral director (b) Address Box 311 Berryville, Ark.

19. (a) 1-4-49 (b) Mrs J. E. W. Cross (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 12 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from 4-17 1981 to 12-12 1948 that I last saw her alive on 11-12 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis (acute) Duration

Due to (Myocarditis)

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 132

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)

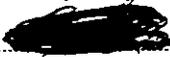
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

Signature A. P. Carter (M: D: or other) Address Berryville Date signed 12/14/48

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.....

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

Signed..... Charles Nelson

Licensed Embalmer No. 815

P. O. Address Box 311 Benning

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan*

Registration District No. *344*

Primary Registration District No. *6157*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Stone Rural*
(b) City or town _____
(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

3. (a) PRINT FULL NAME

Sarah M. Haynes

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 *M*

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

7. Birth date of deceased *April 22 1911*
(Month) (Day) (Year)

8. AGE: Years *73* Months *7* Days *2* If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *Jan. 4, 1949* (b) *Mrs. Elmer Brown*
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* Day *4* Year *1949* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-42214