

FILED FEB 23 1949

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4693

State File No. ....

Registration District No. 137Primary Registration District No. 3023Registrar's No. 40

## 1. PLACE OF DEATH:

(a) County Henry  
 (b) City or town Clinton Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Helzel Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 12 Days  
 In this community 73 yrs 7 Mo 3 Days  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarah Catherine Greenwell

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 John 6. (c) Age of husband or wife if alive 26 years (Day) (Year)  
 7. Birth date of deceased May 26 1875  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 7 3 hr. min.

9. Birthplace Near Lowry City St Clair Co. Missouri  
 (City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business

12. Name John Sherman  
 13. Birthplace Not Given Germany  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Lavine Reese  
 15. Birthplace Tenn.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Gran Greenwell  
 (b) Address Lowry City Mo.

17. (a) Burial (b) Date thereof 2 11 1949  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Landaker Cemetery18. (a) Signature of funeral director H. C. Austin(b) Address Lowry City Mo.

19. (a) Feb 15 - 49 (b) R. R. Remmel  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Clair  
 (c) City or town Lowry City Mo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country ✓

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 9  
 year 1949 hour 10 minute 20 P.M.

21. I hereby certify that I attended the deceased from January 28  
1949 to February 9, 1949  
 that I last saw her alive on February 9, 1949  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Coronary Thrombosis  
 Duration

Due to ArteriosclerosisDue to Smoking

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings: 4 M

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? .....

(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 2

23. Signature W. S. Mott (M. D. or other)Address Clinton Mo Date signed 2 14 49

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer N

District File Number 1-49-11

Date Filed 2-2-14

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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

*H. C. Austin*

Licensed Embalmer No. 3609

P. O. Address: Leamy City, Mo.

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

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