

FILED APR 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13040

State File No.

BIRTH NO. _____ REG. DIST. NO. 385 PRIMARY REG. DIST. NO. 3039 Registrar's No. 219

1. PLACE OF DEATH
a. COUNTY inn.
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marceline
c. LENGTH OF STAY (in this place) 50 yrs
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY inn
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marceline
d. STREET ADDRESS (If rural, give location) 308 W. Curtis

3. NAME OF DECEASED
a. (First) Sarah b. (Middle) Barbara c. (Last) Washburn
4. DATE OF DEATH (Month) (Day) (Year) April 10, 1949

5. SEX Female 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 8. DATE OF BIRTH July 20, 1875 9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months 8 Days 20 IF UNDER 24 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Housewife 11. BIRTHPLACE (State or foreign country) Hebron, Indiana 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Francis Brecount 13b. MOTHER'S MAIDEN NAME Roseanna Lawson 14. NAME OF HUSBAND OR WIFE Rolly Washburn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. no 17. INFORMANT'S SIGNATURE OR NAME Rolly Washburn ADDRESS Marceline, Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bacteremia
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sub mandibular Abscess
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
INTERVAL BETWEEN ONSET AND DEATH 6 hours
5 days
342X

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Oct. 25, 1948, to April 9, 1949, that I last saw the deceased alive on April 9, 1949, and that death occurred at 2 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Philip P. Ottman, M.D. 23b. ADDRESS Marceline, Mo. 23c. DATE SIGNED 4/12/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE April 12, 1949 24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet 24d. LOCATION (City, town, or county) (State) Marceline, Mo.

DATE REC'D BY LOCAL REG. 4/13/1949 REGISTRAR'S SIGNATURE Mary Jane Owen 401 FURNAL DIRECTOR'S SIGNATURE W. Laughlin ADDRESS Marceline, Mo.
(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed..... *Dele Bunch*

Signed.....
Student Embalmer

Licensed Embalmer No. *4088*

P. O. Address *Marceline M*

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.