

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42025**

FILED DEC 19 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **278** PRIMARY REG. DIST. NO. **3054** Registrar's No. **107**

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

1. PLACE OF DEATH a. COUNTY <b>PIKE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>MISSOURI</b> b. COUNTY <b>PIKE</b>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>LOUISIANA</b>	c. LENGTH OF STAY (In this place) <b>1 Day</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>LOUISIANA</b>	
d. FULL NAME OF (If not in hospital of institution, give street address or location) HOSPITAL OR INSTITUTION <b>PIKE COUNTY HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>VANDEVENTER HILL</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>SARAH</b>	b. (Middle) <b>ELLEN</b>	c. (Last) <b>HANCOX</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>DEC. 8, 1949</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>SEPT. 9, 1879</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>29</b>	IF UNDER 2 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEKEEPING</b>	11. BIRTHPLACE (State or foreign country) <b>HARDIN ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>SANFORD ALEXANDER</b>	13b. MOTHER'S MAIDEN NAME <b>SARAH ELLEN GRIFFIN</b>	14. NAME OF HUSBAND OR WIFE <b>W J HANCOX</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT'S SIGNATURE OR NAME <b>MRS. RAY CUNNINGHAM</b>	ADDRESS <b>LOUISIANA MO.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3+ yrs</b> <b>7828</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Master intestinal hemorrhage</b>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Bacteria Disease</b>		

19a. DATE OF OPERATION <b>12/29/48</b>	19b. MAJOR FINDINGS OF OPERATION <b>Enlarged Spleen</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **1948**, to **12/8/49**, 19\_\_\_\_, that I last saw the deceased alive on **12/7, 1949**, and that death occurred at **4:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Chas. H. Linnell</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Louisiana, Missouri</b>	23c. DATE SIGNED <b>12/10/49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>DEC. 11, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>FAIR VIEW CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>LOUISIANA MO</b>
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DATE REC'D BY LOCAL REG. <b>Dec 14, 1949</b>	REGISTRAR'S SIGNATURE <b>Bernice Collier</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J B STERNE</b>	ADDRESS <b>LOUISIANA MO</b>
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