

FILED NOV 15 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32882**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **343**

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Cape Girardeau</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Sikeston, Missouri</b>	
c. LENGTH OF STAY (in this place) <b>16 days</b>		d. STREET ADDRESS (If rural, give location) <b>420 Ruth, St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Francis Hospital</b>			
3. NAME OF DECEASED (Type or Print) <b>Sarah</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>October 26 1950</b>	
a. (First) <b>Sarah</b>		b. (Middle) <b>(n)</b>	
c. (Last) <b>Oliver</b>		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>June 15, 1863</b>		9. AGE (In years last birthday) <b>87</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Tennyson, Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>James Grimes</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Charles Oliver</b>		15. HAS 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. -----		17. INFORMANT'S SIGNATURE OR NAME <b>Mr. Minnie Humbaugh</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>Fractured Neck</b> <b>Fractured Neck</b>		19. ADDRESS <b>Sikeston, Mo.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>Fractured Neck</b> <b>Fractured Neck</b>		19. ADDRESS <b>Sikeston, Mo.</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH <b>About 8 mo</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		e 27030	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		21	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Feb-1950</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <b>Sikeston Scott MO</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) -----		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Fall</b>	

22. I hereby certify that I attended the deceased from **Oct 10, 1950**, to **Oct 26, 1950**, that I last saw the deceased alive on **Oct 25, 1950**, and that death occurred at **6 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W. L. Anderson, M.D.</b>		23b. ADDRESS <b>Sikeston, Mo.</b>		23c. DATE SIGNED <b>11-1-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10-29-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>Sikeston Scott, Missouri</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Taylor Funeral Home</b>		ADDRESS <b>Sikeston, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>11-6-1950</b>		REGISTRAR'S SIGNATURE <b>C. C. Summers</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Taylor Funeral Home</b>	

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

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RECEIVED

NOV 13 1950

DISTRICT HEALTH OFFICE No

File No.....

**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.

Student .....  
Student Embalmer

Signed *J. E. McMillan*

Licensed Embalmer No. *4695*

P. O. Address *Sixteen*

**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.