

FILED DEC 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37474

492

BIRTH NO. _____ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 178

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 416 S. Madison		d. STREET ADDRESS (If rural, give location) 416 S. Madison	
3. NAME OF DECEASED (Type or Print) Sarah		4. DATE OF DEATH (Month) (Day) (Year) Dec. 5, 1950	
a. (First) Sarah		b. (Middle) Catheraine	
c. (Last) Gunning			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 13, 1865
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months 8	IF UNDER 12 HRS. Days 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Broadway, Va.
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Jacob Brenneman		13b. MOTHER'S MAIDEN NAME Catheraine Shank	
14. NAME OF HUSBAND OR WIFE W.S. Gunning (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Fern Vaughan, 514 S. Jefferson		18. ADDRESS W.C. 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Nephritis DUE TO (c) 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)		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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-15, 1950, to 12-5, 1950, that I last saw the deceased alive on 12-5, 1950, and that death occurred at 10:10 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Mrs. Laughter		23b. ADDRESS Webb City, Mo.	
23c. DATE SIGNED 12/7/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec. 8, 1950	
24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		24d. LOCATION (City, town, or county) (State) Webb City, Missouri	
DATE REC'D BY LOCAL REG. Dec 7-50		REGISTRAR'S SIGNATURE S. L. Butcher N.D.	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Johnston-Arnce-Simpson, Webb City, Mo.	

RECEIVED 12-12-50
Jasper County Health Office

County File Number -----

Date Filed 12-12-50 -----

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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 -----

Student Embalmer No. -----

working under my personal supervision.

Student -----
Student Embalmer

Signed Harvey E. Amie -----

Licensed Embalmer No. 4463 -----

P. O. Address Well City, Mo -----

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.