

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41121**

FILED JAN 8 1952

BIRTH NO. _____ REG. DIST. NO. **98** PRIMARY REG. DIST. NO. **5362** Registrar's No. **124**

1. PLACE OF DEATH a. COUNTY Davless		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Davless	
b. CITY OR TOWN Rural Jamesport Twp. c. LENGTH OF STAY (in this place) Life		c. CITY OR TOWN Rural Jamesport Township 0310	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5 Miles N.W. Jamesport Mo.		d. STREET ADDRESS (If rural, give location) 5 Miles N.W. Jamesport, Mo.	

3. NAME OF DECEASED (Type or Print) a. (First) Hannah b. (Middle) --- c. (Last) Saul	4. DATE OF DEATH (Month) (Day) (Year) Dec. 22 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Feb 11 1888	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Wesley Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Soren Jensen	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE George Saul (Dec'd)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, none unknown) (If yes, give way or dates of service) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Miss Dorothy Saul, Jamesport, Mo.	ADDRESS _____
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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 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Uremia		2 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Renal Calculi Kidney removed 2 years ago		
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? 602 YES <input type="checkbox"/> NO <input 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 **June 1951**, to **Dec 22, 1951**, that I last saw the deceased alive on **Dec 22, 1951**, and that death occurred at **5:35P** m., from the causes and on the date stated above.

23a. SIGNATURE J. B. Bailey (Degree or title) _____	23b. ADDRESS Jamesport, Mo.	23c. DATE SIGNED 1-4-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-24-1951	24c. NAME OF CEMETERY OR CREMATORY Pilot Grove No. 2	24d. LOCATION (City, town, or county) (State) Davless County, Missouri
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DATE REC'D BY LOCAL REG. 5 Jan 1952	REGISTRAR'S SIGNATURE Virginia M Engelhart	25. FUNERAL DIRECTOR'S SIGNATURE Hope Funeral Home ADDRESS Gallatin, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

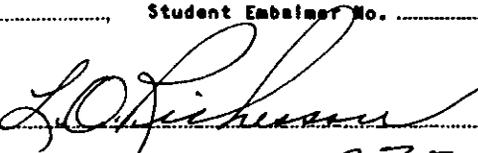
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No.

3302

P. O. Address

Fall River, MA

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.