

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 29 1953

BIRTH NO. _____ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 2017

1. PLACE OF DEATH
a. COUNTY Andrew

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Andrew

b. CITY OR TOWN Rural near Savannah c. LENGTH OF STAY (in this place) _____
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township!) Rural near Savannah 0320

d. FULL NAME OF HOSPITAL OR INSTITUTION SHADY LAWN NURSING HOME d. STREET ADDRESS (If rural, give location) 0

3. NAME OF DECEASED (Type or Print) a. (First) SARAH b. (Middle) MALINDA c. (Last) HANNAH 4. DATE OF DEATH (Month) (Day) (Year) 1-20-1953

5. SEX F 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W 8. DATE OF BIRTH 1-8-1864 9. AGE (In years last birthday) 88 10. MONTH 11 11. DAY 12 12. HOURS 1 13. MINS. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) Jackson Miss 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John W Walker 13b. MOTHER'S MAIDEN NAME Nancy Henderson 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. no 17. INFORMANT'S SIGNATURE OR NAME Mr. J. D. Hannah Bolckow mo ADDRESS _____

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Robert pneumonia

MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Robert pneumonia INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 480X 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 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 12-15, 1952 to 1-20, 1953, that I last saw the deceased alive on 1-19, 1953, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE Donald W. ... (Name or title) 23b. ADDRESS ... 23c. DATE SIGNED 1-21-53

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE 1-22-1953 24c. NAME OF CEMETERY OR CREMATORY Bolckow 24d. LOCATION (City, town, or county) (State) Bolckow mo

DATE REC'D BY LOCAL REG. 1-22-53 REGISTRAR'S SIGNATURE Lillian Sparks 25. FUNERAL DIRECTOR'S SIGNATURE Breit Funeral Home Savannah Mo ADDRESS _____

(Licensed Embalmer's Statement on Reverse Side)

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

60 20
4

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.