

FILED FEB 20 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5720

BIRTH NO. _____		REG. DIST. NO. <u>239</u>		PRIMARY REG. DIST. NO. <u>5825</u>		Registrar's No. <u>64</u>			
1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>					
b. CITY (If outside corporate limits, write RURAL, and give town(ship)) <u>Tallapoosa</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Tallapoosa</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City</u>				e. STREET ADDRESS (If rural, give location) <u>0 12 0</u>					
3. NAME OF DECEASED (Type or Print) <u>SARAH</u>			a. (First)		b. (Middle)		c. (Last) <u>McCOOL</u>		
4. DATE OF DEATH <u>FEB. 5, 1956</u>			4. DATE (Month) (Day) (Year)		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>			8. DATE OF BIRTH <u>Dec. 7, 1888</u>		9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>28</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Clara Sargent, St. Louis, Mich. Rte. 3</u>			ADDRESS	
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) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>					
				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 <u>331x</u>			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 <u>Jan 22, 1956</u> to <u>Feb 5, 1956</u> , that I last saw the deceased alive on <u>Feb 5, 1956</u> , and that death occurred at <u>5 P. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Dr. Geo. W. Hunt</u> M.D.				23b. ADDRESS <u>Carma, Mo.</u>			23c. DATE SIGNED <u>2/10/56</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 8, 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Gilead Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Gideon, Missouri</u>			
DATE REC'D. BY LOCAL REG. <u>2/10/56</u>		REGISTRAR'S SIGNATURE <u>Dr. Geo. W. Hunt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Landess Funeral Home, Campbell, Mo.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED FEB 16 1956  
NEW MADRID CO. HEALTH CENTER  
P. J. S.

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.....  
Signature of Student Embalmer

Signed Christina M. Landess

Licensed Embalmer No. 422

P. O. Address Campbell

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.