

FILED OCT 14 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1076

300
-57

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | c. CITY OR TOWN St. Joseph | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 824 Dewey Ave., | | d. STREET ADDRESS 2725 No. 12th St., | |
| Length of stay in lb 60 Yrs. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last Sarah E. Torbert | | | 4. DATE OF DEATH Month Day Year October, 5, 1957 | | |
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| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December, 9, 1870 | 9. AGE (In years last birthday) 86 Yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
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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 Home | 11. BIRTHPLACE (City and state or country) Polo, Missouri | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Samuel Teagarden | 13b. MOTHER'S MAIDEN NAME Sarah Glenn | 14. NAME OF HUSBAND OR WIFE James M. Torbert |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Samuel p. Torbert, South Gate, California |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency | | INTERVAL BETWEEN ONSET AND DEATH Unk. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Broken Compensation | | Unk. |
| | DUE TO (c) Passive Congestion of Liver | | Unk. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 410X | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
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| 21. I attended the deceased from <u>10/4/57</u> to <u>10/5/57</u> and last saw <u>him</u> alive on <u>10/4/57</u> Death occurred at <u>12:50A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) St. Melaney M.D. | 22b. ADDRESS St. Joseph, Mo. | 22c. DATE SIGNED 10/5/57 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE October, 8, 1957 | 23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | 23d. LOCATION (City, town, or County) (State) St. Joseph Missouri |
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| 24. FUNERAL DIRECTOR St. Mary's Funeral Home | ADDRESS St. Joseph, Missouri | 25. DATE RECD. BY LOCAL REG. Oct. 11, 1957 | 26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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
Signature of Student Embalmer

Signed *George A. Herb*

Licensed Embalmer No. *4752*

P. O. Address *Joseph, N.J.*

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.