

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6284

FILED MAR 13 1945

Registration District No. 1069

Primary Registration District No. 3023

Registrar's No. 50

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

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution General  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 23 Days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry 42

(c) City or town Martrase 0  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Catherine Kahn

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 24  
year 1945 hour 9 minute 56 A.M.

21. I hereby certify that I attended the deceased from Jan 31, 1942, to Feb 24, 1945;  
that I last saw her alive on Feb 24, 1945;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single; widowed, married, divorced Widow

6. (b) Name of husband or wife Salomon Kahn 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 16 1858  
(Month) (Day) (Year)

Immediate cause of death None of the right heart -  
Arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) None

Major findings: Of operations None

Of autopsy None

8. AGE: Years 86 Months 5 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Oneida Ill. (City, town, or county) (State or foreign country) 1

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

12. Name George Marsh

13. Birthplace USA (City, town, or county) (State or foreign country) 1

14. Maiden name SARAH JANE STEELE

15. Birthplace USA (City, town, or county) (State or foreign country) 1

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Carl Kahn

(b) Address Deepwater Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation Martrase Cemetery

18. (a) Signature of funeral director Spore and Son

(b) Address Clinton Mo

19. (a) February 26, 1945 (Date received by registrar) (b) Jay Kitchey Deputy (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) VD

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury VD

23. Signature S. B. Hughes (M. D. or \_\_\_\_\_)  
Address Clinton, Mo. Date signed 2/24/45

1069

Office No. 7

Number 2-45-172

Date Filed 2-9-45

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, ~~of~~.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed *W. J. Causant*

Licensed Embalmer No. *3779*

P. O. Address *Blanton*

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.