DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

36852

State File No.

FILED DEC 14 1942

Registration District No. 33 — Primary Registration District No. 4080 — Registrar's No. 144

1. PLACE OF DEATH:
(a) County: Carroll
(b) City or town: Norborne
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community: 30 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Carroll
(c) City or town: Norborne
(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 M. MYERS
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Harvey Myers
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: March 8 1864 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	8	21	hr. min.

9. Birthplace: Ray County (City, town, or county), Mo (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Daniel B. Bowman
13. Birthplace: Harrisonburg Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Sarah A. Showalter
15. Birthplace: Harrisonburg Virginia (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Chas. Schiebel
(b) Address: Norborne Missouri

17. (a) Buried Norborne Mo (Burial, cremation, or removal) (b) Date thereof: Dec 1 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Fairhaven Cem.

18. (a) Signature of funeral director: W. T. Strand
(b) Address: Norborne Mo

19. (a) 12-7-42 (Date received local registrar) (b) Mrs. James Rafferty (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 29th year 1942 hour 12 minute Noon M.

21. I hereby certify that I attended the deceased from February 19th, 1942, to November 29th, 1942, that I last saw her alive on November 29th, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cancer and other malignant tumors of the digestive tract	more than one year
Due to	
Due to	

Other conditions (Include pregnancy within 3 months of death): Ventral abdominal hernia of several years duration.

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: A. J. Gardner (M.D. or other)
Address: Norborne, Mo. Date signed: 12-1-42

1:33

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District ... Officer No. 8,

District File Number ....

Date Filed 12-10-42

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 ...... M. T. Stroud ......, Registered Apprentice No. 2406 working under my personal supervision.

Signed M. T. Stroud

Licensed Embalmer No. 2406

P. O. Address Norborne M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36852

Registration District No. 55 Primary Registration District No. 4080 Registrar's No. 144

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Norborne
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah M Myers
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar 8 18[illegible] (Month) (Day) (Year)
8. AGE: Years 78 Months 8 Days [illegible] If less than one day hr. min.
9. Birthplace (City, town, or county) MO (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

SUPPLEMENTARY

20. DATE OF DEATH: Month Nov day 29 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cancer & other malignant tumor of the digestive tract	more than one yr
Due to Originating in	
Due to the liver	
Other conditions (Include pregnancy within 3 months of death) Ventral abdominal hernia of several year duration	
Major findings: Of operations	PHYSICIAN
Of autopsy	Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature A J Gardner (M. D. or other)
Address Date signed

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

S-36852