DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35711

Registration District No. 124 Primary Registration District No. 4070 Registrar's No. 35

1. PLACE OF DEATH:
(a) County Cape Girardeau (b) City or town Jackson (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 years, months or days) In this community Fifty Years

2. USUAL RESIDENCE OF DECEASED:
(a) State S (b) County
(c) City or town Same (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Gertrude Josephine Pierce Sachs
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 Married
6. (b) Name of husband or wife Leo F. Sachs
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) Aug. (Day) 12 (Year) 1882

8. AGE: Years 57 Months 2 Days 12 If less than one day hr. min.
9. Birthplace Jackson (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name John Pierce
13. Birthplace Jackson (City, town, or county) Mo. (State or foreign country)
MOTHER 14. Maiden name Sharon Brooks
15. Birthplace Jackson (City, town, or county) Mo. (State or foreign country)
16. (a) Informant's own signature Ted M. Sachs
(b) Address Jackson Mo
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10-25-1939 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetary
18. (a) Signature of funeral director W. Coombs Funeral Home
(b) Address Jackson, Mo.
19. (a) 10-25-39 (Date received local registrar) (b) D. G. Seibert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 24th year 1939 hour 2:30 minute P M.
21. I hereby certify that I attended the deceased from 12-14-38, 19, to 10-24, 1939, that I last saw her alive on 10-24-1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral apoplexy	
Due to: High Blood pressure	
Due to:	
Other conditions (Include pregnancy within 3 months of death): None	

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 William Estes (M. D. or other)
Address Jackson, Mo. Date signed 10-25-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should stat CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

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

working under my personal supervision.

Signed..... B. H. Meyer

Licensed Embalmer No. 3035-1

P. O. Address Jackson 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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

35711
Do not use this space.

1. PLACE OF DEATH
(a) County Cape Girardeau Registration District No. 124
(b) Township Jackson Primary Registration District No. 4070 Registered No.
(c) City Jackson (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 2nd Gertrude Josephine Pierce Sachse?

(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	2	12	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 2-13 1940 D. G. Seibert
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 29 1939

22. I HEREBY CERTIFY, That I attended deceased from ..., 19.., to ..., 19....
I last saw h... alive on ..., 19.... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ... Date of ...
What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19....
Where did injury occur? ...
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
...
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...
(Signed) Abel M. Estes, M. D.
(Address) Jackson Mo

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.