LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

[illegible]462

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

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

1 PLACE OF DEATH

County Henry

Township Clinton

or

Village

or

City ~~Clinton~~ (NO. ..... St. ..... Ward)

Registration District No. 350 File No. 825

Primary Registration District No. ~~5478~~ 5488 Registered No. 22

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sarah Jane Ward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Mon 14 (Month) (Day), 1835 (Year)

7 AGE 87 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Ohio

PARENTS

10 NAME OF FATHER Joel Burton

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Saint Kinney

12 MAIDEN NAME OF MOTHER Margaret Miller

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mary Lind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. V. Cook

(Address) Clinton R.R.

15

Filed Jan 14, 1922 Ed C. Peelor G.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 (Month) 1 (Day), 1922 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 12-31-, 1921, to 1-1-, 1922, that I last saw her alive on 12-31-, 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) 1 yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Kelly M. D.

....., 191.... (Address) La Due Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel Grove

DATE OF BURIAL Jan 4, 1922

20 UNDERTAKER Lewis Wilkinson

ADDRESS [illegible]

LOCAL REGISTRAR'S RE NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ..... (Year)

7 AGE
..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day) ..... (Year), 191.....

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL
....., 191.....

20 UNDERTAKER

ADDRESS