OCT 24 1927

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

Do not use this space.

26391

1. PLACE OF DEATH

County: Andrew

Registration District No. 16

File No.

Township: Rochester

Primary Registration District No. 5020

Registered No. 12

City: ~~Helena~~ (No. ... St. ... Ward)

2. FULL NAME Sarah Ann Brown

(a) Residence. No. ... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

5a. If Married, Widowed, or Divorced HUSBAND OF (or) WIFE OF: John W. Brown

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb. 16 –

7. AGE: Years 79, Months 6, Days 29. If LESS than 1 day, ... hrs. or ... min.

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

9. BIRTHPLACE (CITY OR TOWN): Unknown.
(STATE OR COUNTRY): Tenn.

PARENTS

10. NAME OF FATHER: James Hampton

11. BIRTHPLACE OF FATHER (CITY OR TOWN): Unknown.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER: Cynthia Williamson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Unknown.
(STATE OR COUNTRY)

14. INFORMANT: A. G. Brown
(Address): Helena Mo

15. FILED: Sept 16, 1927 Mrs. Bettie Boggs, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 15, 1927

17. I HEREBY CERTIFY, That I attended deceased from March 29, 1926, to Sept 15, 1927, that I last saw her alive on Sept 15, 1927, and that death occurred, on the date stated above, at 8–15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cirrhosis of the liver

122 B1

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY): Arteriosclerosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas L Allen, M. D.

Sept. 16, 1927 (Address) Easby Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Union Chapel Cemetery

DATE OF BURIAL: 9/17 1927

20. UNDERTAKER: H. [illegible] Wilson

ADDRESS: King City

...d. AGE should be stated EXACTLY. PHYSICIANS should ... Exact statement of OCCUPATION is very important ... properly classified.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Andrew — Registration District No. 16 — File No.

Township Rochester — Primary Registration District No. 5820 — Registered No. 12

City (No. , St. Ward)

2. FULL NAME Sarah Anne Brown

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 16 1848

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

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

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED Sept 16 27 Mrs. Bettie Boyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1927

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) , M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY L

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