

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

Do not use this space.

2301

1. PLACE OF DEATH

County Lewis
 Township.....
 City La Grange (No.)

Registration District No. 480
 Primary Registration District No. 4289

File No.
 Registered No. 4 (Ward) St.

2. FULL NAME Sarah Foeze

(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 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 11th 1852

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
 76 5 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 194B
 (b) General nature of industry, business, or establishment in which employed (or employer) 102
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) New London
 (STATE OR COUNTRY) No.

10. NAME OF FATHER Edward Priest

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Mrs E.L. Jackson
 (Address) La Grange

15. FILED 1/18 1929 W.S. Roberts
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16th 1929

17. I HEREBY CERTIFY, That I attended deceased from August, 1924, to Jan 16th, 1929, that I last saw her alive on Jan 16th, 1929, and that death occurred, on the date stated above, at 12 o'clock P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture of R. Hip complicated by hyperemia
 (duration) 4 yrs. 8 mos. ds.

CONTRIBUTORY (SECONDARY) Apoplexy
 (duration) 4 yrs. 8 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Leucine acid magenta

(Signed) Dr. L. C. Calk P.O. No.
 , 19 (Address) La Grange, 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 La Grange **DATE OF BURIAL** Jan 18 1929

20. UNDERTAKER A.A. Roberts **ADDRESS** La Grange

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FEB 22 1929
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