

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

Do not use this space.

24612
3024

1. PLACE OF DEATH

County Jackson Registration District No. 1002
Township Kaw Primary Registration District No. _____
City Kansas City Mo. 435 Smalley St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Sarah Elizabeth Turber
(a) Residence, No. 435 Smalley St., 10 Ward.

(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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 29 - 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 7 30

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Self at Home
(c) Name of employer _____

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

Barrol Co. Missouri

10. NAME OF FATHER Thomas Meredith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Mary Baker

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

14. INFORMANT (Address) Frank Meredith

15. FILED 7/11 1929 M. M. Croive REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 10 1929

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1928, to July 10, 1929, that I last saw her alive on July 7, 1929, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of stomache and yall or bowels. Trachea.
4 1/2 B
127 B (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at her home

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) A. H. Burge, M. D.
7/11 1929 (Address) Independence 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 Mound Grove Cem. DATE OF BURIAL 7/12 1929

20. UNDERTAKER W. H. Barson Son ADDRESS Judyp. Mo.

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.

WHITE PAPER, WITH IMPAGING INK—THIS IS A PERMANENT RECORD

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