

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

Do not use this space.

38127

1. PLACE OF DEATH

County Randolph Registration District No. 135
Township _____ Primary Registration District No. 3034
City Moberly (No. 801 No. Morley) St. _____ Ward _____

File No. _____
Registered No. 216
St. _____ Ward _____

2. FULL NAME Sarah Frances Mullier

(a) Residence. No. 801 No. Morley 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) _____

Female White Widow.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5th 1881

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	78	4	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
(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) Mo

10. NAME OF FATHER August Bailey

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

12. MAIDEN NAME OF MOTHER Amanda Powell

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

14. INFORMANT W. A. Esry (Address) Huntsville, Mo

15. FILED 11/6 1929 Dr. Thos. S. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1. 1
16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 3rd 1929

17. I HEREBY CERTIFY, That I attended deceased from 13th Nov, 1929, to Nov 3rd 1929, that I last saw her alive on 2nd Nov, 1929, and that death occurred, on the date stated above, at 2:30 A. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral Calosis

45 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Ulc (duration) yrs. mos. ds.

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

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

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? not tested
(Signed) W. S. Megee M. D.

11-5th 1929 (Address) Moberly, 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 Moberly Mo. DATE OF BURIAL Nov. 5th 1929

20. UNDERTAKER Mahoney Son ADDRESS Moberly Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. 202 would be stated EXACTLY. PHYSICIANS should state EXACTLY. 202 would be stated EXACTLY. PHYSICIANS should state EXACTLY.

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8-2-29

