

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

Do not use this space.

4917

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 1000 W 71st Street)

Registration District No. 399
Primary Registration District No. 1002

File No. 507
Registered No. 507
St. 8 Ward 8

2. FULL NAME Sarah A. Dalton

(a) Residence. No. 1000 W 71st Street St. 8 Ward.

(Usual place of abode) 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. (If nonresident, give city or town and State)

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) Nov. 20, 1842

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 87 2 16

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) Missouri

10. NAME OF FATHER Adison Price

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

12. MAIDEN NAME OF MOTHER Marguerite Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT Mrs. J. O. Miller
(Address) 1000 West 71st St Terrace

15. FILED 77 30 M. M. Browne REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 6 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1922, to Feb 6, 1930, that I last saw her alive on 2-4, 1930, and that death occurred, on the date stated above, at 7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Multiple Salivari
Gland
87B (duration) 7 yrs. 1 mos. 1 ds.

CONTRIBUTORY (SECONDARY) None (duration) 0 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRIBUTED IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF 6

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clywood
(Signed) Frank B. Bailey M. D.
2-6, 1930 (Address) 317 E. 800 St

*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 Butler, Mo. DATE OF BURIAL Feb. 8.30

20. UNDERTAKER R. V. Lindsey & Sons, Inc. ADDRESS Kansas City 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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