

JUN 24 1930

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

Do not use this space.

15572

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

1. PLACE OF DEATH
County Cass Registration District No. 157
Township Grand River Primary Registration District No. 1
City Harrisonville (No. _____) St. _____ Ward _____

2. FULL NAME Sarah Malinda Clements
(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 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 25-1837

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
93 - 15 -

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

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

10. NAME OF FATHER Wm H. Holoway

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

12. MAIDEN NAME OF MOTHER May A. Beck

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

14. INFORMANT Miss Clements
(Address) Harrisonville, Mo

15. FILED 5/17/30 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/10 1930

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 10, 1930, that I last saw him alive on May 10, 1930, and that death occurred, on the date stated above, at 11:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Urgemic Coma with chronic nephritis
121
137 B (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 129 A (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

20. WAS THERE AN AUTOPSY: _____

21. WHAT TEST CONFIRMED DIAGNOSIS: J. West, M. D.
(Signed) _____, 19 _____ (Address) Harrisonville

*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 Oakland DATE OF BURIAL 5/12 1930

20. UNDERTAKER Remmaburger Bros Rev Harrisonville ADDRESS _____

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.

