

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

Do not use this space.

31523

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **Merced** (No. **City Hospital**)

File No.....
 Registered No. **9136**
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. **23** Ward. **Merced, Mexico**
 (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) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Unknown**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
abt. 21				

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. **Homemaker**
 (b) General nature of industry, business, or establishment in which employed (or employer). **0**
 (c) Name of employer _____

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

10. NAME OF FATHER **Jose Sarcia**

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

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Merced, Mexico**

14. INFORMANT (Address) **Dr. Roman**
City Hospital

15. FILED **22** 19**30**
Max C. Stankoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 21 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Sept 21 1930** to **Sept 21 1930**
 that I last saw him alive on **Sept 21 1930** and that death occurred, on the date stated above, at **6:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lungs.
23 A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **21** (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical X-ray, & biopsy**
 (Signed) **Raymond Jacobs** M.D.
9/21/30 (Address) **City Hospital**

*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 **Parado Texas.** DATE OF BURIAL **9-23 1930**

20. UNDERTAKER **Michael Naval** ADDRESS **1905 - 19th**

Exact statement of OCCUPATIONAL STATUS, if any, to be given.

so that it may be properly classified.

Sarcia

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