

SEP 6 1939

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

28141
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Law Primary Registration District No. 1007
 (c) City Iteso (d) Street No. 112 Sun Hosp Registered No. 3143
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah Kay
 (a) Residence, No. 7825 Wilson Ave St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 26 - 1899

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
<u>69</u>	<u>7</u>	<u>11</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

FATHER

13. NAME Anderson Harrison

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

MOTHER

15. MAIDEN NAME Susan Harmon

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT (ADDRESS) Record Clerk 112 Sun Hosp

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Floral Hills DATE 8-9-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Shiel Funeral Home 2606 Maple St

20. FILED 8 1939 M. M. Groue Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-7-39, 1939

22. I HEREBY CERTIFY, That I attended deceased from 7-27-39 to 8-7-39, 1939.
 I last saw her alive on 8-7-39, 1939. Death is said to have occurred on the date stated above, at 4:15 p. m.
 The principal cause of death and related causes of importance were as follows:
myocardial infarction
cross and coronary sclerosis
hypertensive changes
pneumonia + Pulm. Infarct

Other contributory causes of importance:
hypertensive changes
pneumonia + Pulm. Infarct

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) P. J. De Maria, M. D.
 (Address) 2606 Maple St

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No. 3625 -

P. O. Address 6606 Independence Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.