WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE...

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.

...RESERVED FOR BINDING

PLACE OF DEATH

County Cape Gir

Township Hubble

or

Village

or

City White Water (NO. ..... St.: ..... Ward)

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

Registration District No. 130 File No. 38178

Primary Registration District No 4073, Registered No. 10.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Sarah Eveline Huckstep

PERSONAL AND STATISTICAL PARTICULARS

SEX: Woman

COLOR OR RACE: W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Mch (Month) 2 (Day), 1843 (Year)

AGE: 69 yrs. 5 mos 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Gordenville, Mo.

PARENTS

NAME OF FATHER: Logan Kinder

BIRTHPLACE OF FATHER (City or town, State or foreign country): D.K.

MAIDEN NAME OF MOTHER: Jane Kinder Neer

BIRTHPLACE OF MOTHER (City or town, State or foreign country): D.K.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. M. Huckstep

(ADDRESS) Whitewater, Mo.

Filed Dec 22, 1914 A. M. Murphy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month), 21 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 21, 1914, to Dec 21, 1914, that I last saw her alive on Dec. 21, 1914, and that death occurred, on the date stated above, at 8 P.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

74A

80

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Murphy M. D.

Dec. 22, 1914 (Address) Whitewater Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Kinder Cestry

DATE OF BURIAL: Dec 22 1914

UNDERTAKER: H. H. Hinkle

ADDRESS: [illegible]

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTI
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward) [If dea hospital give its of street

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1 _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) (D

I HEREBY CERTIFY, that I attended de _____, 191__, to _____ that I last saw h_____ alive on _____ and that death occurred, on the date stated above, The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mo

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mo

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violen (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, T RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ m

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF B
UNDERTAKER	ADDRESS