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.

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

PLACE OF DEATH

County: Lawrence

Township: Freistatt

or Village:

or City: (NO. , St.: Ward)

Registration District No. 473 File No. 1 1610

Primary Registration District No. 5637 Registered No. 1

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

FULL NAME Sarah Jane McNatt

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: May (Month) 15 (Day), 1874 (Year)

AGE: 40 yrs. 7 mos. 29 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS

NAME OF FATHER: A. C. McNatt

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

MAIDEN NAME OF MOTHER: Celia Cummings

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. C. McNatt

(ADDRESS) Hoberg Mo

Filed Jan 15, 1915. H. F. Kaiser REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan 14 (Month) (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 23, 1914, to Jan 14, 1915, that I last saw her alive on Jan 14, 1915, and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

46D

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Carlos Copeland M. D.

Jan 14, 1914 (Address) Freistatt 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: Spanish Fork

DATE OF BURIAL: 1/16/15, 191

UNDERTAKER: L. B. Orr

ADDRESS: Mt Vernon 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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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 death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., 1.....
(Month) (Day) (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

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to....., 191...., that I last saw h.....alive on....., 191...., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed)..... M. D.

....., 191.... (Address).....

*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	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS