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: Knox

Township: Liberty

or Village:

or City: (NO. St.; Ward)

Registration District No. 441 File No. 2050

Primary Registration District No. 6245 Registered No. 27

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

FULL NAME: Sarah Crim

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Sept 5 (Month) (Day), 1837 (Year)

AGE: 78 yrs. 2 mos. 7 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Franklin Co Ind

PARENTS
NAME OF FATHER: John Burk
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky
MAIDEN NAME OF MOTHER: Hariet Tucker
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Thomas Burk

(ADDRESS): Edina Mo

Filed Jan 10, 1916. H. J. Jurgens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: November (Month) 12 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 10, 1915, to Nov 12, 1915, that I last saw her alive on Nov 11, 1915, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

131
Convulsions (Uremic)
132 A 120
2 days (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY): Nephritis Chronic
unknown (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Geo S Brown M. D.
11/15, 1915 (Address) Edina 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: Davis Cemetery

DATE OF BURIAL: Nov 16, 1915

UNDERTAKER: Kriegshauser Bros

ADDRESS: Edina Mo

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

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.