

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.

PLACE OF DEATH

County Stone
 or
 Township Washington
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 843 File No. 8793
 Primary Registration District No. 6106 Registered No. _____

FULL NAME

Sarah Ann Blair

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE Married
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

DATE OF BIRTH Sept. 22, 1860
 (Month) (Day) (Year)

AGE 56 yrs. 5 mos. 4 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) Mo.

PARENTS
 NAME OF FATHER Walden
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know
 MAIDEN NAME OF MOTHER Mary Skill
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry McDowell
 (ADDRESS) Galena Mo.

Filed 9/28 1917 J. Henson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 26, 1917
 (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:

92 Lobar Pneumonia
 (Duration) No yrs. No mos. 7 ds.

Contributory No
 (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.
 (Signed) J. Henson M. D.
9/28 1917 (Address) Galena 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 Yocum Pond Cemetery DATE OF BURIAL Feb. 27, 1917
 UNDERTAKER Craig Mercantile Co. ADDRESS Galena Mo.

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

**SINGLE
MARRIED
WIDOWED
OR DIVORCED**
(Write the word)

(Month)	(Day)	(Year)

REGISTRAR