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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 781 File No. 31069
or
Village ..... Primary Registration District No. 1003 Registered No. 8958
or
City St. Louis (No. 129 Convent St.; 7 Ward)

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

2 FULL NAME Sarah McDonald

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH Sept. 26th (Month) (Day) 1918 (Year)

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) St. Louis

PARENTS

10 NAME OF FATHER Clarence McDonald

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) St. Louis

12 MAIDEN NAME OF MOTHER Sarah Ryan

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Rath
(Address) Coroner's Office

15 Filed SEP 27 1918 Max C. Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 26th (Month) (Day) 1918 (Year)

17 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 7-00 p.m.

The CAUSE OF DEATH* was as follows:
Congenital Debility
15 1
1931 N.M.C.

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

CONTRIBUTORY (Secondary) Premature Birth 7 M Gest
Twin
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Rath M.D.
9/27 1918 (Address) Deputy Coroner

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

18 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 129 Convent St.

19 PLACE OF BURIAL OR REMOVAL Calvary Cem. DATE OF BURIAL Sept. 27 1918

20 UNDERTAKER Jno. T. Ellis ADDRESS 1039 N. Grand Ave.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1 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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day.....hrs. or.....min.?

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

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS