LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 36113

or Village ..... Primary Registration District No. 1003 Registered No. 9480

or City St. Louis Mo. (NO. City Hospital St.; 70 Ward)

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

7919 2 FULL NAME Sarah Rivers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April (Month) 20 (Day), 1890 (Year)

7 AGE 28 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER Nellson Sims

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

12 MAIDEN NAME OF MOTHER Minerva Dobs

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Information Otto N. Fritsch

(Address) City Hospital

15 Filed OCT 13 1918 19 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 11 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 30, 1918, to Oct 11, 1918, that I last saw her alive on Oct 11, 1918, and that death occurred, on the date stated above, at 9:00 p.m.

The CAUSE OF DEATH* was as follows:

Salpingitis

Pelvic Abscess 13V

139B (Duration) ..... yrs. ..... mos. ..... ds.

129 CONTRIBUTORY (Secondary) General Peritonitis

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

(Signed) Emil E. Heim M. D.

Oct. 12, 1918 (Address) City Hospital

*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 2 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

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

Former or usual residence 3526 Cozens

19 PLACE OF BURIAL OR REMOVAL Greenwood DATE OF BURIAL Oct 14, 1918

20 UNDERTAKER A E Mulick ADDRESS 312 Vitton St.

LOCAL REG... DO NOT TEAR LEAF...

... OF HEALTH
... STICS
...

1 PLACE OF DEATH

County ....

Township .... or

Village .... or

City ....

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

2 FULL NAME ....

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH
3 SEX	4 COLOR OR RACE	DATE OF DEATH .... (Month) .... (Day), 191.......... (Year)
6 DATE OF BIRTH .... (Month) .... (Day) 1.......... (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.
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)		CONTRIBUTORY (Secondary) .... (Duration) ....yrs. ....mos. ....ds.
PARENTS: 10 NAME OF FATHER		(Signed) ....M. D.
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)		.........., 191.......... (Address) ....
12 MAIDEN NAME OF MOTHER		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)		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 ....
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) .... (Address)		19 PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL ...., 191..........
15 Filed ...., 191.........., ... Registrar		20 UNDERTAKER — ADDRESS

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