JUN 25 1927

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

Do not use this space.

14671

1. PLACE OF DEATH

County Dekalb — Registration District No. 209 — File No.

Township ~~Camden~~ — Primary Registration District No. 4158 — Registered No.

City Maysville. (No. ..... St. ..... Ward)

2. FULL NAME Sarah Eliza Hofstatter.

(a) Residence. No. ..... St., ... Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: Wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ethan A, Hofstatter

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept. 1st. 1858

7. AGE: Years 68 — Months 8 — Days 8 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home.

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

PARENTS

10. NAME OF FATHER: Ethan A, Daniels.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio

12. MAIDEN NAME OF MOTHER: Sarah Dunlap

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio.

14. INFORMANT: Ethan A. Hofstatter (Address) Maysville.

15. FILED 5/10 1927 J. 2 Phelps REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5/8 1927

17. I HEREBY CERTIFY, That I attended deceased from December 1926, to May 8 1927 that I last saw her alive on May 8, 1927, and that death occurred, on the date stated above, at 11 a.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer (Carcinomatosis of all abdominal organs)

8 48

5 2 E

1 2 3 E

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Obstruction, enterostomy

Feb. 10, 1927 (duration) yrs. 3 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [signature], M. D

5/10, 1927 (Address) Maysville Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Oak Lawn Cem. Maysville — DATE OF BURIAL: May 10 1927

20. UNDERTAKER: U. G. Pilcher — ADDRESS: Maysville.

14501
250
751

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: DeKalb — Registration District No. 259 — File No.
Township: — Primary Registration District No. 4158 — Registered No.
City: Maysville (No. ... St. ... Ward)

2. FULL NAME Sarah Eliza Hafstatter

(a) Residence No. ... St., ... Ward, ... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. — 4. COLOR OR RACE: W. — 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): W.

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ... min.

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

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 3/10 1927 — J. L. Phillips — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 1927

17. I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19..., that I last saw h... alive on ... 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer, Carcinomatosis of all abdominal organs
Cancer of Uterus
(duration) 15 yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY) Obstruction enterostomy
(duration) ... yrs. 3 mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED? 46
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? ... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) G. S. Johnson, M. D.
8/27, 1927 (Address) Maysville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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