PLACE OF DEATH

County Warren

Township Charrette

or

Village

or

City (NO. St.; Ward)

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

Registration District No. 8 8 4 File No. 20489

Primary Registration District No. 6 1 7 8 Registered No. 2 0

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

FULL NAME Sarah Frances Browning

V. S. No. 2.

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

MARGIN RESERVED FOR BINDING

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: October (Month) 14th (Day) 1849 (Year)

AGE: 77 yrs. 7 mos. 26 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): Maryland, U.S.

NAME OF FATHER: Unknown.

BIRTHPLACE OF FATHER (City or town, State or foreign country): Maryland.

MAIDEN NAME OF MOTHER: Unknown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. F. Sturm

(ADDRESS) Marthasville Mo.

Filed June 11, 1927 G C Johnson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 10 (Month), 1927 (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 1926 to June 10, 1927, that I last saw her alive on June 12, 1927, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation 95° 90A 16 (Duration) ....yrs. ....mos. ....ds.

Contributory (SECONDARY) Old age 8 (Duration) ....yrs. ....mos. ....ds.

(Signed) G C Johnson M. D.

....., 191.... (Address) Marthasville 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 1 yrs. 1 mos. 6 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: Marthasville Mo

DATE OF BURIAL: June 13, 1927

UNDERTAKER: Fred W Lichtenberg

ADDRESS: Marthasville Mo

MARGIN RESERVED FOR BINDING

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in hospital or institutio give its NAME inste of street and number]

PLACE OF DEATH

County _____

Township _____ or

Village _____ or

City _____ (NO. _____ St.: _____ Ward)

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 fro _____, 191___, to _____, 191___

that I last saw h_____ alive on _____, 191___

and that death occurred, on the date stated above, at _____ r

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ d

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ d

(Signed) _____ M.

_____, 191___ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ d

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