

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.

AUG 16 1927

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

Do not use this space.

21223

387

**1. PLACE OF DEATH**

County..... Harrison  
 Township..... Bethany  
 City.....

Registration District No. 334  
 Primary Registration District No. 4197

File No. ....  
 Registered No. ....  
 St. .... Ward)

**2. FULL NAME**

Sarah Belle Hegner

(a) Residence. No. .... St. .... Ward. ....  
 (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. (If nonresident give city or town and State)

**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 OR (OR) WIFE OF**

Samuel Hegner

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

4-13-1859

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>68</u>	<u>3</u>	<u>14</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House wife  
 (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) Harrison Co. Mo.

**10. NAME OF FATHER**

Francis M. Spence

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Sassell Co. Virginia

**12. MAIDEN NAME OF MOTHER**

Lucinda Lockhart

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Virginia

**14.**

INFORMANT Samuel Hegner  
 (Address) Bethany Mo.

**15.**

FILED 8/10 19 27 W. H. Hamel  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

3

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 7-27 1927

**17. I HEREBY CERTIFY, That I attended deceased from** .....  
 ....., 19....., to ..... 19.....  
 that I last saw her alive on 7/27, 1927, and that death occurred, on the date stated above, at 12 P m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Failing cardiac compensation due to nephritis.

95 (duration) 3 yrs. .... mos. .... ds.  
**CONTRIBUTORY** nephritis heart trouble  
 (SECONDARY) and dropsy (duration) 6 yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

**IF NOT AT PLACE OF DEATH** .....  
**8 DID AN OPERATION PRECEDE DEATH?** ..... DATE OF .....  
 WAS THERE AN AUTOPSY? .....

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) H. P. Hallaway, D. O.

7-28, 1927 (Address) Bethany 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**

Miriam Cemetery

7-29 1927

**20. UNDERTAKER**

Bethany Mo.

S. M. Searis

