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

Do not use this space.

JUL 27 1927

1. PLACE OF DEATH
County Laclede — Registration District No. 932 — File No. 21817
Township Franklin — Primary Registration District No. 5 1 6 17 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Grace Sartewell

(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Guy Sartewell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 21-1902

7. AGE: YEARS 25 — MONTHS 11 — DAYS 17 — If LESS than 1 day, ... hrs. or ..... min.

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) Competition
(STATE OR COUNTRY) Laclede Co Mo

PARENTS
10. NAME OF FATHER W. T. Stewart
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Houston Mo
12. MAIDEN NAME OF MOTHER Ruby French
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Competition
(STATE OR COUNTRY) Mo

14. INFORMANT Guy Sartewell
(Address) Competition Mo

15. FILED June 19 27 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4 1927

17. I HEREBY CERTIFY, That I attended deceased from July 1 1927, to July 4, 1927 that I last saw her alive on July 3, 1927 and that death occurred, on the date stated above, at 1 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Typhoid Fever
Lobar Pneumonia

108 (duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam
(Signed) P. Thompson, M. D.
, 19 (Address) Lebanon 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: Competition Cem — DATE OF BURIAL: 7/5 1927

20. UNDERTAKER: Holman & Stewart — ADDRESS: Lebanon Mo

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
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Laclede Registration District No. 952 File No.

Township Franklin Primary Registration District No. 5617 Registered No.

City (No. , St. Ward)

2. FULL NAME Grace Sartewell

(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 F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 21, 1902

7. AGE X YEARS 24 MONTHS 11 DAYS 13 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 June 19 27 Isabelle Lewis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4 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:

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. 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) , M. D

, 19 (Address)

*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

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.

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

S-32817