Space

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

Do not use this space.

23896

SEP 27 1927

1. PLACE OF DEATH

County: Clay — Registration District No.: 198

Township: N. River — Primary Registration District No.: 3011

City: Excelsior Springs (No. ..... St. ..... Ward)

File No.: ..... Registered No.: 104

2. FULL NAME: Martha Sarah Saunders

(a) Residence. No. 214 Prospect St., ..... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred: 2 yrs. 1 mos. 15 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

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

5a. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF: S. C. Saunders

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 30 - 1865

7. AGE: Years 61 | Months 8 | Days 28 | 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): Ray Co Mo

PARENTS

10. NAME OF FATHER: Wm Morrisch

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

12. MAIDEN NAME OF MOTHER: Elizabeth Martin

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

14. INFORMANT: D. L. Shepherd
(Address): 307 Park Ave Clarendon Ia

15. FILED: 8/29 1927 — Geo. D. Crouch, Registrar

## 3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8-28-1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1927, to Aug 28, 1927, that I last saw ..... alive on Aug 27, 1927, and that death occurred, on the date stated above, at 5:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastric Ulcer, C Hemorrhage

11731

12713

116C

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY): Cholecystitis

..... (duration) ..... yrs. Renal

18. WERE ANY OPERATIONS PERFORMED? ✓

IF NOT AT PLACE OF DEATH? ✓

DID AN OPERATION PRECEDE DEATH? No. DATE OF: —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

Aug 29, 1927 (Signed): John F. Hoch, M.D.
(Address): Excelsior Springs 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: Union, Ray Co Mo — DATE OF BURIAL: 8/30 1927

20. UNDERTAKER: Herbert Hope — ADDRESS: Exc Springs

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.