

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

Do not use this space.

25975

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *City Report*)

File No.

Registered No. **7595**

2. FULL NAME *Sadie Ferris*

(a) Residence. No. *5943 Arsenal* St. *3* Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. mos. 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 *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 9 - 1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *60 9 15*

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Isr -*
(b) General nature of industry, business, or establishment in which employed (or employer) *102*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY)

10. NAME OF FATHER *James Cass*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Ireland*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Sarah Ingram*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Ireland*
(STATE OR COUNTRY)

14. INFORMANT (Address) *City Report*

15. **AUG 26 1927** *mar 6 Starkeoff*
FILER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 24 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Aug 15* 19*27* to *Aug 24* 19*27*, that I last saw *her* alive on *Aug 24* 19*27*, and that death occurred, on the date stated above, at *1:30* p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS
*Metastatic Obstruction
General Carcinomatosis*

CONTRIBUTORY *Carcinoma of uterus*
(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) *J. M. Smith* M. D.

St. Louis (Address) *City Report*

*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 *Cuba Mo* DATE OF BURIAL *Aug 27 1927*

20. UNDERTAKER *Hausk & Schmitt* ADDRESS *3732*

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.

Jams