

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

Do not use this space.  
*Trucker*  
26987  
File No. ....  
Registered No. *582* ...

1. PLACE OF DEATH  
County *Greene* Registration District No. *318*  
Township *Springfield* Primary Registration District No. *Della 2001*  
City *Springfield* (No. *611*) *Della* St. .... Ward) ....  
2. FULL NAME *611 Sarah Devol*  
(a) Residence. No. *611* *Della* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female*  
4. COLOR OR RACE *white*  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF   
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 6-1839*  
7. AGE YEARS *88* MONTHS *2* DAYS *21* 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) *N. Y.*  
10. NAME OF FATHER *Clark Cummings*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*  
12. MAIDEN NAME OF MOTHER *Esther Curtis*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

14. INFORMANT (Address) *Esther Hoffman*  
*Clifton Forge, Va.*  
15. FILED *9/27 27* REGISTRAR *Oct 1st 1927*

**MEDICAL CERTIFICATE OF DEATH**

2  
16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 27 1927*  
17. I HEREBY CERTIFY, That I attended deceased from *Sept 16* to *Sept 27*, 1927, and that I last saw him alive on *Sept 25*, 1927, and that death occurred, on the date stated above, at *10 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS  
*Apoplectic Stroke*  
*74061*  
CONTRIBUTORY (SECONDARY) *Age*

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH, .....  
(1) DID AN OPERATION PRECEDE DEATH? *no* DATE OF .....  
WAS THERE AN AUTOPSY? *no*  
WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy*  
(Signed) *C. Tucker*, M.D.  
*9/27*, 1927 (Address) *638 Landers*  
\*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 *Dellview cemetery* DATE OF BURIAL *Apr 28 1927*  
20. UNDERTAKER *W. Klingner* ADDRESS *No. 4 24th Paul Springfield, Mo.*

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.

