

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

Do not use this space.

29644

1. PLACE OF DEATH

County Buchanan Registration District No. 86 File No. _____
 Township Washington Primary Registration District No. 5127 Registered No. 87
 City St. Joseph (No. Industrial City) St. _____ Ward _____

2. FULL NAME Sarah Catherine Thomas

(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 33 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 (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5, 1852.

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>75</u>	<u>4</u>	<u>17</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Samuel Prewitt

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mattie Witter
 (Address) St. Joseph R F D No. 2.

15. Oct 24, 1927 J. J. Sauerbae
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 22, 1927

17. I HEREBY CERTIFY, That I attended deceased from 10/16, 1927, to 10/16, 1927 that I last saw her at alive on 10/16/27, 19____, and that death occurred, on the date stated above, at 10/15p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy
7401 (duration) yrs. mos. ds. 6
 CONTRIBUTORY Unknown
 (SECONDARY) B2A (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

B DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS: Physiocal
 (Signed) J. H. Gray, M. D.

Oct. 24, 1927 (Address) 1725 Commercial

*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 Ashland Cemetery DATE OF BURIAL Oct. 24 1927.

UNDERTAKER H. O. Sidenfaden ADDRESS 1802 Union Str

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PARENTS

