

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

Do not use this space.

Allee
30977

1. PLACE OF DEATH
 County Miller Registration District No. 561
 Township Eldon Primary Registration District No. 4330
 City Eldon (No. _____) St. _____ Ward _____

2. FULL NAME Sarah Agnes Atkinson
 (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.

File No. _____
 Registered No. 57

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 L. J. Atkinson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-23-1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
77 | 8 | 2 | _____

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) Miller Co
 (STATE OR COUNTRY) MO

10. NAME OF FATHER P. S. Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Miller Co
 (STATE OR COUNTRY) MO

12. MAIDEN NAME OF MOTHER Ruby Ann McKnight

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Colo Co
 (STATE OR COUNTRY) MO

14. INFORMANT Maggie Haynes
 (Address) Eldon

15. FILED 11-1-27 Belle Haynes
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-25 1927

17. I HEREBY CERTIFY, That I attended deceased from 11/10/24 to 10-25-1927 that I last saw her alive on 10/24/27, 19____, and that death occurred, on the date stated above, at _____ A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetic Coma
59 (duration) yrs. mos. 3 ds.
 CONTRIBUTORY Diabetes & Diabetic
 (SECONDARY) Gaugme Rt foot & toe
 (duration) 5 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) W. Allee, M. D.
 , 19____ (Address) Eldon 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 St. Pleasant DATE OF BURIAL 10/27 1927

20. UNDERTAKER W. G. Phillips ADDRESS Eldon

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.

